

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR - STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME (TYPE OR PRINT) <b>EDWARD ELWOOD BAUMGARDNER</b>				2b. HOUR <b>8:30 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>09 28 07</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>76</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WSTM - NURSING/CONV. CENTER</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>SELF EMPLOYED BAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>MARYLAND</b>		13b. CITY OR TOWN <b>CARROLL</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>107 TREVANION RD. 21787</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Merle S. Baumgardner</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Lottie M. Hilterbrick</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			
16b. SOCIAL SECURITY NO. <b>216-32-6459</b>		17. INFORMANT <b>Naomi H. Baumgardner</b>		ADDRESS <b>107 Trevanion Rd. Taneytown, MD 21787</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Severe CHF and Renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple myocardial infarctions</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>3 days</b> <b>5 yrs</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <b>N/A</b>							
19a. DATE OF OPERATION <b>N/A</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>N/A</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>N/A</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <b>N/A</b>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <b>N/A</b>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <b>N/A</b>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>N/A</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>8/19</b> , 19 <b>84</b> , to <b>8/30</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>8/28</b> , 19 <b>84</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>John W. Middleton MD</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/30/84</b>	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John W. Middleton MD</b>		22d. ADDRESS <b>182 East Main Street Westminster Md</b>					
23b. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23c. DATE <b>Sep. 2, 1984</b>		23d. NAME OF CEMETERY OR CREMATORY <b>Trinity Lutheran Cem.</b>		23e. LOCATION CITY OR TOWN COUNTY STATE <b>Taneytown, Carroll, Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>Skiles Funeral Home</b>		136 E. Baltimore St. TANETOWN, MD 21787		25a. DATE REC'D. BY REGISTRAR <b>SEP 05 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendall</b>	

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FILED

TO: [illegible]  
FROM: [illegible]  
SUBJECT: [illegible]

FILED

DATE: [illegible]  
TIME: [illegible]  
BY: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 22013			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Elizabeth BeMiller</i>				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR <i>08 01 84 0900 M</i>			
3. SEX <i>F</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11 27 06</i>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. <i>77</i> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll Co.</i> MD.	
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>West Md. Conv. Ctr</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			
13a. STATE <i>Md.</i>		13b. COUNTY <i>CARROLL</i>		13c. CITY OR TOWN <i>Westminster</i>		13e. STREET ADDRESS <i>17 Park Ave. 21157</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Charles Wesley Bemiller</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sarah Conner</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>213-16-8261</i>		17. INFORMANT <i>Ms. Patricia R. Dimeo</i>		ADDRESS <i>4850 Mt. Hay Dr. San Diego, CA 92117</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of ovary</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 yrs</i>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION _____		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED _____		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) _____			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) _____		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____			
22a. I certify that (1) (this hospital) attended the deceased from _____, 19____, to <i>8-1</i> , 19 <i>84</i> , that (1) (we) lost <i>saw the deceased alive on 7-31-84</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Alva S. Baker</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8-1-84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alva S. Baker</i>				22e. ADDRESS <i>28 West Harts Med Ctr Westminster MD 21157</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Removal</i>		23b. DATE <i>8/1/84</i>		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____	
24. FUNERAL DIRECTOR NAME <i>Anatomy Board</i>				ADDRESS <i>Balto., Md.</i>		25a. BY REG. NO. <i>AUG 7 1984</i> 25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>MARIE E. BROWN</b>					8 21 84		1320		M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Dec. 16, 1894		89 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Carroll County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminister		Carroll County General Hospital						House wife			
13a. STATE		13b. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS / ZIP CODE					
Maryland		Baltimore		Towson		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		305 E. Joppa Road 21204			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST				16. ADDRESS			
Newton Thornburg				Ada L. Pasquith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS					
No		213-20-0213		Wayne Brown		331 Kenmore Ave., Belair, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>PNEUMONIA BILATERAL</b>										1 WEEK	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a											
<b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/16, 19 84, to 8/21, 19 84, that (I) (we) last saw the deceased alive on 8/21, 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
		Vincent Fiocco, M.D.		MD				8/21/84			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial		Aug. 25, 1984		Parkwood Cemetery		Parkville Balto., Md.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Ruck Towson Funeral Home, Inc.		1050 York Road		AUG 23 1984		John Davidson-Randall					

MEDICAL CERTIFICATION



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 4 2 2 0 1 5			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Marjorie Viola Chew				2a. DATE OF DEATH MONTH DAY YEAR 8 12 84			
3. SEX Female				4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1910	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION):							
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Owings Mills		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Hoxter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Viola Lane			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-09-6704		17. INFORMANT 204 Pleasant Hill Rd. Louis N. Chew Owings Mills, Md. 21117			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE RESPIRATORY INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>PNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>CHRONIC OBSTRUCTIVE PULMONARY DISEASE</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CONGESTIVE HEART FAILURE</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>7/26, 1984</u> to <u>8/12, 1984</u> , that (I) (we) last saw the deceased alive on <u>8/12, 1984</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Vincent J. Fiocco, Jr.</u> MD				22c. DATE SIGNED 8/12/84		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent J. Fiocco, Jr.	
22e. ADDRESS Westminster, Maryland							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 15, 1984		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial Gardens		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Carroll, Md.	
24. FUNERAL DIRECTOR NAME <u>Raymond H. Heston</u>				25. DATE REC'D BY REGISTRAR 6 15 1984		25a. REGISTRAR'S SIGNATURE <u>John Davidson</u>	
Eckhardt Funeral Chapl Owings Mills, Md.							

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**STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ralph Thomas Coe			2a. DATE OF DEATH MONTH DAY YEAR 8 21 84		2b. HOUR 2109 M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 10 20 1895	6. AGE (IN YEARS LAST BIRTHDAY) 88 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Carroll Co. Md.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.		
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) D.P. Smelser	12b. KIND OF BUSINESS OR INDUSTRY Plumbing-Heat ing	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN New Windsor	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John Coe			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Bowers		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-14-0329	17. INFORMANT ADDRESS 100 Coe Drive Pearl B. Coe New Windsor, Md. 21776		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILUREAPPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATHWEEKS

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASEYEARS

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

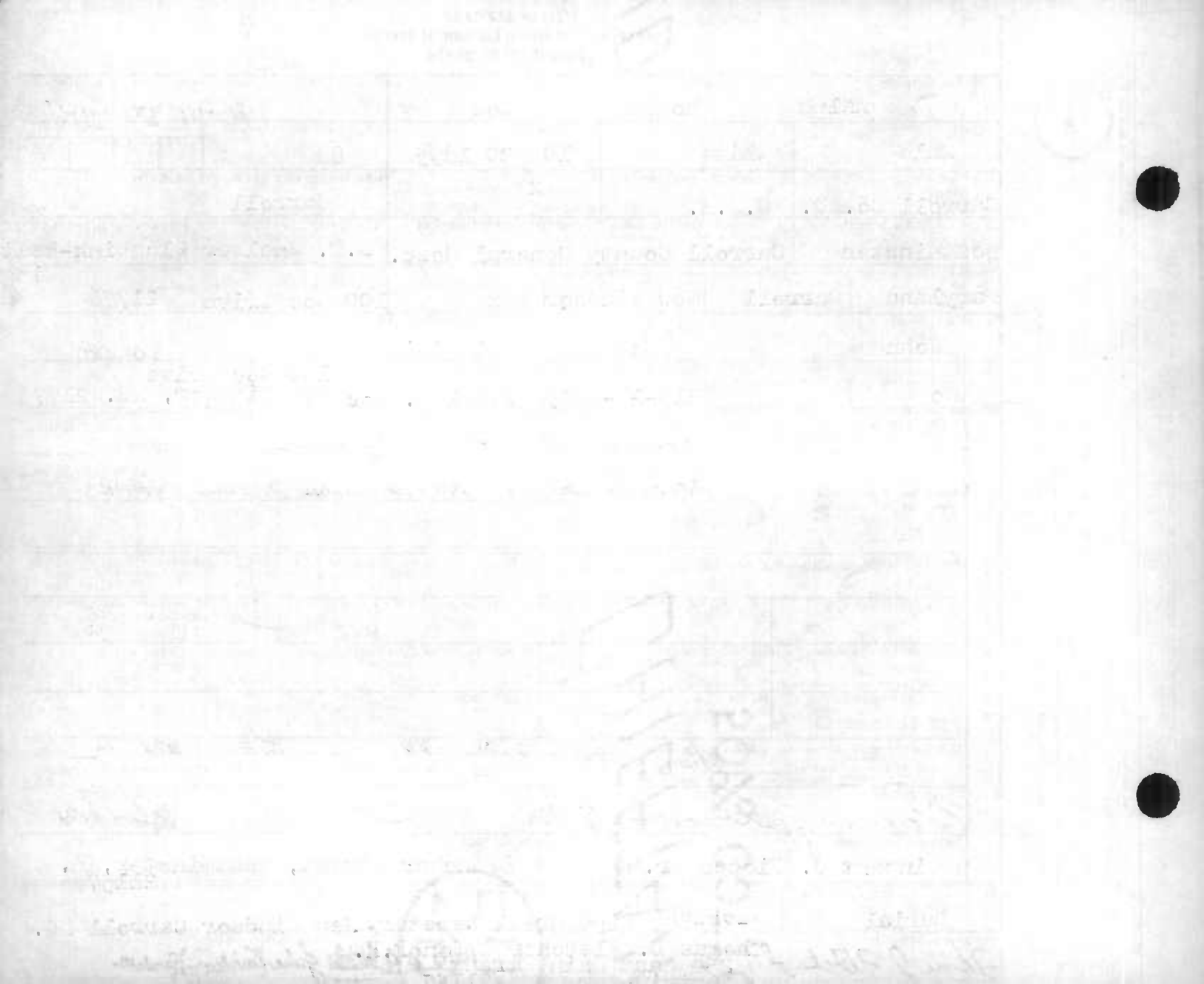
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>7/31</u> , 19 <u>84</u> , to <u>8/21</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>Vincent J. Fiocco Jr.</u>		DEGREE <u>MD</u>		22c. DATE SIGNED <u>8/21/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent J. Fiocco Jr. MD		22e. ADDRESS 8 Anchor Street, Westminster Md.			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 8-24-84	23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery New Windsor Carroll Md.	23d. LOCATION CITY OR TOWN COUNTY STATE
24. FUNERAL DIRECTOR NAME Thomas J. Fletcher		25a. DATE REC'D. BY REGISTRAR AUG 24 1984	
25b. REGISTRAR'S SIGNATURE <u>Julia F. [Signature]</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>FRIEDA CRONHARDT</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 25 1984</b>			2b. HOUR <b>12:30 P.M.</b>					
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11. 13. 1901</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.					
10. CITY OR TOWN OF DEATH <b>MANCHESTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>LONG VIEW NURSING HOME</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>HOUSEWIFE</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE <b>MARYLAND</b>			13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>WESTMINSTER</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>113 ANCHOR STREET 21157</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Sauter</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ella C. Stern</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-18-0523</b>		17. INFORMANT <b>F.L. CRONHARDT</b>				ADDRESS <b>113 ANCHOR ST. WEST, MD.</b>		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBROVASCULAR ACCIDENT</b>			
DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC CARDIO-VASCULAR</b>			
DUE TO, OR AS A CONSEQUENCE OF (c) <b>DISEASE</b>			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: **NONE**

19a. DATE OF OPERATION <b>—</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>not seen before 8-25</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>5-25</b> , 19 <b>84</b> , and that it (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Morjaria</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8.25.84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>SURENDRA D. MORJARIA</b>				22e. ADDRESS <b>3125 MAIN STREET, MANCHESTER, MD. 21102</b>			

23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>8-28-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery Westminster Carroll Md.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME <b>Thomas O. Fletcher Westminster Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1984</b>			
				25b. REGISTRAR'S SIGNATURE <b>Julius Davidson-Randall</b>			

BP



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Mildred C. DIXON			2a DATE OF DEATH MONTH DAY YEAR 8 12 84			2b HOUR 6:54 M			
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 12, 1925		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD			
10 CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 509 S. Main St.				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland		13b COUNTY Carroll		13c CITY OR TOWN Mt. Airy		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 509 S. Main St. 21771	
14 FATHER'S NAME FIRST MIDDLE LAST Edward Lee Christmas				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Texie Chestnut					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 240-24-9346		17 INFORMANT Lewis C. Dixon,		ADDRESS Item 13			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cadaveric Spontaneous Aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Mitral Regurgitation Bicuspid Aortic</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer, Terminal</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>11-12</u> , 19 <u>82</u> , to <u>8-12</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>7-31</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Clinton G. Hoverson</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED <u>8-13-84</u>			
22d PHYSICIAN'S NAME (TYPE OR PRINT) <u>Arthur G. Hoverson, MD</u>				22e ADDRESS <u>GREEN VICTORY CIRCLE, ANNAPOLIS MD 21778</u>					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 15, 1984		23c NAME OF CEMETERY OR CREMATORY Pine Grove		23d LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll Md.			
24 FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A., Damascus, Md. A116 15 1984									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The certificate should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



1917  
June 1, 1917  
U.S. Navy  
Bureau of Naval Affairs  
Washington, D.C.  
Dear Sir:  
Enclosed for you are  
two copies of a report  
on the subject of  
the proposed  
amendment to the  
Naval Appropriation  
Bill for the fiscal  
year 1918.  
Very respectfully,  
John D. Long  
Secretary of the Navy

*[Faint, mostly illegible handwritten text follows, appearing to be a memorandum or letter body.]*

Very truly yours,  
John D. Long  
Secretary of the Navy

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>RUSSELL ELLSWORTH FEESER</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>24</b> YEAR <b>1984</b>		2b. HOUR <b>7:30 a</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Dec.</b> DAY <b>11</b> YEAR <b>1914</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>69</b> YRS.		IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b> HOURS <b></b> MIN <b></b>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b>		
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hosp.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Factory Rep. Ret.</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home Mfrg.</b>		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Crouse Mill Road 21787</b>			
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>							
14. FATHER'S NAME FIRST <b>Russell</b> MIDDLE <b>Samuel</b> LAST <b>Feeser</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Mathilda</b> MIDDLE <b>Agnes</b> LAST <b>Baker</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>212-32-2407</b>		17. INFORMANT ADDRESS <b>Crouse mill Road Mrs. Genevieve Feeser Taneytown, Md. 21787</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive &amp; arteriosclerotic cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on <u>Autopsy</u> <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Margarita A. Korell</b>				TITLE (SPECIFY) <b>Assistant</b>				DATE SIGNED <b>8-24-84</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Margarita A. Korell, M.D.</b>				ADDRESS <b>111 Penn St., Balto., Md. 21201</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 27, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Grace U.C.C. Cemetery</b>			23d. LOCATION CITY OR TOWN <b>Taneytown</b> COUNTY <b>Carroll</b> STATE <b>Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Skiles Funeral Home</b> ADDRESS <b>136 E. Balto. Street Taneytown, Md. 21787</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 29 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Johanna Davidson Randall</b>			



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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

8 4 2 2 0 2 0

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Otho Jefferson Fleming			2a. DATE OF DEATH MONTH DAY YEAR 8 30 84			2b. HOUR 06.30 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR July 20 1911		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mt. Airy, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11 Washington Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Electrician		12b. KIND OF BUSINESS OR INDUSTRY Aviation	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Otho Augustus Fleming		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elsie Gunn		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 219-10-0500	
17. INFORMANT Carrie Bair Fleming		ADDRESS 11 Washington Lane Westminster, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>METASTATIC CARCINOMA OF PROSTATE</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): <u>ARTERIO SCLEROTIC CARDIO VASCULAR DISEASE</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH MONTHS	

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 <u>78</u> , to <u>8/30</u> , 19 <u>84</u> , that (I) (we) lost saw the deceased alive on <u>7/19</u> , <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Vincent J. Fiocco Jr. MD</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/31/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent J. Fiocco Jr. MD		22e. ADDRESS 8 Anchor Street, Westminster, Md. 21157					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-2-84		23c. NAME OF CEMETERY OR CREMATORY Taylorsville		23d. LOCATION CITY OR TOWN COUNTY STATE Taylorsville Carroll Md.	
24. FUNERAL DIRECTOR NAME <u>Gal. Flota</u>		ADDRESS Thomas D. Fletcher & Son 254 East Main Street Westminster, Md. 21157		25a. DATE REC'D. BY REGISTRAR SEP 05 1984			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1- FOR STATE REGISTRAR AKA HELEN			1 DECEASED NAME (TYPE OR PRINT) HELENA E. FOULLOIS		2a. DATE OF DEATH MONTH DAY YEAR 8 28 84	
3. SEX FEMALE		4 RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 8 29 1883		2b. HOUR 1452 M
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Germany		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 100 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY ---				
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14 FATHER'S NAME FIRST MIDDLE LAST August Unknown		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amelia Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-22-8581		17 INFORMANT ADDRESS Albert Catrino 2330 Liberty Rd. 21784		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>BRONCHOPNEUMONIA</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE - ARTERIAL OCCLUSION (L) LEG</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/28</u> , 19 <u>84</u> , to <u>8/28</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8/28</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <u>[Signature]</u>				DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>[Signature]</u>				22e. ADDRESS Carroll County General Hospital		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/30/84		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland
24 FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc. 4107 Wilkens Ave.				25. DATE RECEIVED BY REGISTRAR AUG 31 1984		26. REGISTRAR'S SIGNATURE <u>[Signature]</u>

A

10% COPY



1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

1- FOR  
STATE  
REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Merton L. Franklin</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-13-84</b>			2b. HOUR <b>2354</b> M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Nov. 5, 1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <b>88 9 8</b>		7. UNDER 1 YEAR IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <b>9 8</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. General Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Farmer-Retired</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Mt. Airy</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Thomas N. Franklin</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Rosie Ellen Young</b>			16. ADDRESS <b>Sykesville, Md.</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>217-36-4593</b>		17. INFORMANT ADDRESS <b>Ruth A. Haines, 4762 Sykesville Rd.</b>				

18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED

20a. AUTOPSY?

20b. IF YES, WERE FINDINGS USED  
IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐  
OR CONTRIBUTING ☐ CAUSE OF DEATH  
(IF EITHER, NOTIFY MEDICAL EXAMINER)

21b. TIME OF INJURY  
HOUR A.M. MONTH DAY YEAR  
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐  
AT WORK AT WORK

21e. PLACE OF INJURY  
(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)21f. LOCATION  
STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **8-13-84** to **8-13-84**, that (I) (we) lost  
saw the deceased alive on **8-13-84**, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated  
above, in (we) (did) (did not) view the body after death.

22b. SIGNATURE

DEGREE

ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☐

22c. DATE SIGNED

22d. PHYSICIAN'S NAME (TYPE OR PRINT)

22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL  
(SPECIFY) **Burial**23b. DATE  
**8-17-1984**23c. NAME OF CEMETERY OR CREMATORY  
**Taylorville**23d. LOCATION  
CITY OR TOWN COUNTY STATE  
**Taylorville, Carroll, Md.**

24. FUNERAL DIRECTOR

NAME  
**Charles W. Burrier, Jr., Sykesville, Md.**

25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE

**AUG 17 1984** *Julia Davidson Randall*

NOT RECORDED  
IN THE  
OFFICE OF THE  
CLERK OF THE  
COURT

Marion	Franklin				
Male	White	Nov. 2, 1882	28	9	8
Marion	U.S.A.		Carroll Co.,		
Westminster	Carroll Co. General Hospital		Franklin		
Marion	Carroll Co. Army		28	9	8
Thomas	Franklin		Young		
			Franklin		
			Franklin		

Handwritten notes and signatures, including a large signature at the bottom.

Charles W. Burrier, Jr., Sykesville, Md.  
8-17-1934  
Sykesville, Md.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RICHARD LIONEL GILLIS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUG 18 1984</b>		2b. HOUR <b>1525M</b>
3. SEX <b>MALE</b>	4. RACE <b>W</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>OCT 18 1929</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>54</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL MD.</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL CO. GEN HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>LABORER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>PAINT + CHEMICAL</b>
13a. STATE <b>MARYLAND</b>	13b. COUNTY <b>FREDERICK</b>	13c. CITY OR TOWN <b>UNION BRIDGE</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>LIONEL GILLIS</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CHRISTINA BUCKEL</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>217-24-4506</b>		17. INFORMANT ADDRESS <b>UNION BRIDGE MD</b> <b>JEANNETTE GILLIS 11401A BEAVER DAM RD</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CENTRAL NERVOUS SYSTEM - RESPIRATORY FAILURE 3 DAYS</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>POST CARDIAC ARREST 78 DAYS</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD - ENCEPHALOPATHY 2 YEARS</b>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>JUNE 2 1984</b> to <b>AUG 18 1984</b> , that (I) (we) last saw the deceased alive on <b>AUG 18 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Daniel J. Welliver MD</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8-18-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DANIEL J. WELLIVER MD.</b>		22e. ADDRESS <b>218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
<b>BURIAL</b>	<b>AUG 21 1984</b>	<b>ST PETERS</b>		<b>LIBERTY TOWN MD</b>	
24. FUNERAL DIRECTOR NAME ADDRESS <b>DD Hartzler Union Bridge Md</b>		24b. DATE REC'D BY REGISTRAR <b>AUG 22 1984</b>		24c. REGISTRAR'S SIGNATURE <b>J. Davidson Handell</b>	

MEDICAL CERTIFICATION

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

BP

STANDARD



20% COTTON FIBER

MADE IN U.S.A.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Baby Boy "A" Golden				2a. DATE OF DEATH MONTH DAY YEAR April 19, 1984				2b. HOUR 6:30 P.M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 19 1984		6. AGE (IN YEARS LAST BIRTHDAY) ----- YRS.		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS. HRS. MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY -----			
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4103 Teklen Drive 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Stephen Quentin Golden				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carol Sue Allan							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				16b. SOCIAL SECURITY NO. -----		17. INFORMANT ADDRESS Mother - See #15 See #13e					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Immaturity Associated</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>W. H. Polyhydramnios</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Immature</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION (CITY OR TOWN STREET) COUNTY STATE							
22a. I certify that on this hospital's attendance the deceased from low the deceased alive or above (three) did (did not) show the body after death.											
22b. SIGNATURE <i>Richard A. Jones</i>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 7/31/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Richard A. Jones M.D.		22e. ADDRESS Carroll County General Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 04-19-84		23c. PLACE OF BURIAL, CREMATION, OR REMOVAL Carroll County General Hospital		23d. LOCATION (CITY OR TOWN COUNTY STATE) Westminster Carroll MD					
24. FUNERAL DIRECTOR Charles Graf, Exec. Vice-Pres.		Westminster, MD		21157		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 27 1984 Julia Davidson-Randall					

BP



*[Faint, illegible handwriting, possibly bleed-through from the reverse side of the page.]*

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**STATE OF MARYLAND**  
**DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>Teresa THERESA</b>			First Middle Last			2a. DATE OF DEATH Month <b>AUG.</b> Day <b>26</b> Year <b>1984</b>			2b. HOUR <b>1:30</b> M.		
3. SEX <b>Female</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>JUNE 11, 1882</b>			6. AGE (In years last birthday) <b>102</b> YRS.		
7a. BIRTHPLACE (State or foreign country) <b>BALTIMORE, MD</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>CARROLL COUNTY</b> Md.		
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>CARROLL CO. GEN. HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>NONE</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>NONE</b>		
13a. USUAL RESIDENCE (Where deceased lived if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>BALTO.</b>			13c. CITY OR TOWN <b>BALTO.</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER <b>#21234</b>			13f. STREET AND NUMBER <b>PESSENGER PKWY. &amp; OAKLEIGH RD</b>			14. FATHER'S NAME First Middle Last <b>UNKNOWN</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b. SOCIAL SECURITY NO. <b>212-07-6936</b>			17. INFORMANT <b>BRUCE HANLEY, ESQ.</b> Address <b>400 ALLEGHENY AVE. TOWSON, MD 21204</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>cardio pulmonary arrest</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>aspiration</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>ASCVD</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 min</b> <b>30 min</b> <b>20 hrs</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/16/84</b> , 19 <b>84</b> , to <b>8/27/84</b> , 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>8/16/84</b> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>J. H. Levinson</b>			22c. PHYSICIAN'S NAME (Type) <b>SOL LEVINSON</b>			22d. ADDRESS <b>104 N. MAIN ST. UNION BRIDGE, MD</b>			22e. DATE SIGNED <b>8/27/84</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <b>AUG. 29, 1984</b>			23c. NAME OF CEMETERY OR CREMATORY <b>KNESSETH ISRAEL ANSHE KOLK</b>			23d. LOCATION (City or Town) (County) (State) <b>BALTIMORE MARYLAND</b>		
24. FUNERAL DIRECTOR <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>						25a. REC'D BY REGISTRAR <b>AUG 30 1984</b>			25b. REGISTRAR'S SIGNATURE <b>Carla Davidson-Randall</b>		



SECTION



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anne Victoria Graham			2a. DATE OF DEATH MONTH DAY YEAR 8 12 84			2b. HOUR 7:40 P.M.			
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 1 31 1932		6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick County		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Finksburg		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Edward Derr			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Victoria Mullican			16. STREET ADDRESS / ZIP CODE 2551 Baltimore Blvd. 21048			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 220-28-2997		17. INFORMANT ADDRESS 2551 Baltimore Blvd. Richard T. Graham Finksburg, Md. 21048				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Ca of color with liver and hepatic metastases</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 4 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION 9 Aug 84			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca of color with obstruction and metastases			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8 Aug 1984 to 12 Aug 1984, that (I) (we) saw the deceased alive on 12 Aug 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Donald D. Coker MD			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED 12 Aug 84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Coker MD			22e. ADDRESS 222 Washington Heights Medical Center Westminster, Md 21157						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-13-84		23c. NAME OF CEMETERY OR CREMATORY Carroll Cremation Services		23d. LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.		
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H.			25a. DATE REC'D. BY REGISTRAR AUG 15 1984						
25b. REGISTRAR'S SIGNATURE John Davidson-Randall									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Clara Blanche Heron</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 14 84</b>			2b. HOUR <b>0150A.M.</b>				
3. SEX <b>Female</b>		4. RACE <b>Cau</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 15 98</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll General</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>			
13a. STATE <b>Md.</b>		13b. COUNTY <b>Howard</b>		13c. CITY OR TOWN <b>West Friendship</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
13e. STREET ADDRESS <b>3505 Rt. 32</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>CLARA Deborah HAMBURG</b>								
14. FATHER'S NAME FIRST MIDDLE LAST <b>ISAAC Theodore CROUSE</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>No</b>								
16b. SOCIAL SECURITY NO. <b>213 38 7445</b>		17. INFORMANT ADDRESS <b>Diane Deering-Smith - W. Friendship Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma tain</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma Coloa</b> DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION <b>8/7/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Small obstruct</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <b>8/7/84</b> 19 <b>84</b> to <b>8/14</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>8/13</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>John E. Steers</b> MD				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/14/84</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John E. Steers</b>				22e. ADDRESS <b>222 Washington Hts Westminster Md</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-16-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bolton Nat. Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>				
24. FUNERAL DIRECTOR NAME ADDRESS <b>Harry W. Haight Sykesville, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1984</b>					25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

MEDICAL CERTIFICATION

29

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post a may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 1-800-368-6868.

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CHICKEN



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Edwin Hobson</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>August 14, 1984</b>			2b. HOUR AM PM <b>5:00 AM</b>				
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Aug. 16, 1919</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>64</b> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.				
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>6012 Snowdens Run Rd. 21784</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Maintenance</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>6012 Snowdens Run Rd. 21784</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Edgar Hobson</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Amelia Rappanier</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>			16b. SOCIAL SECURITY NO. <b>WW II 214-18-2297</b>		17. INFORMANT ADDRESS <b>Mrs. Patricia A. Ellis Same as # 13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF THE LUNG</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 YR</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a <b>RADIATION PULMONARY FIBROSIS</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>MAY 9</b> , 19 <b>84</b> , to <b>AUG 14</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>JULY 13</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Paul E. Gormley</i>			DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <b>8/14/84</b>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Paul E. Gormley, M.D.</b>			22e. ADDRESS <b>900 S. Caton Ave. Balto., Md. 21229</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/16/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lorraine Mausoleum</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Woodlawn Baltimore, Md.</b>			
24. FUNERAL DIRECTOR NAME <b>MacNabb Funeral Home</b>			ADDRESS <b>Catonsville, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 16 1984</b>		25b. REGISTRAR'S SIGNATURE <i>John Davidson-Hendell</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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20% COLLOID

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>JOHN William HUBER SR</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>AUG 1 1984</b>		2b. HOUR <b>0359 PM</b>
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>APR 21 1923</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>61</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Spring City, Pa</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S. P.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL MD</b>	
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL CO. GEN HOSP</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Supervisor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>3-M</b>
13a. STATE <b>Maryland</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Westminster</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS <b>244 Sophic Ave. #137</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Clyde Huber</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Magret Briedenbach</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WA OR FATES) <b>NO IL</b>		17. INFORMANT ADDRESS <b>Eleanor R. Huber same as #13</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE 1 HOUR.</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>CHRONIC OBSTRUCTIVE PULMONARY DIS 10 YEARS</b> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <b>AUG 1 1984</b> , to <b>AUG 1 1984</b> , that I (we) lost saw the deceased alive on <b>AUG 1 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Daniel J. Welliver</b>		DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/1/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>DAMEL I. WELLIVER MD.</b>		22e. ADDRESS <b>218 WASHINGTON HEIGHTS WESTMINSTER MD 21157</b>			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <b>Burial</b>		23b. DATE <b>8-4-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial</b>	
23d. LOCATION (CITY OR TOWN) COUNTY <b>Fincksburg Carroll Md.</b>		24. FUNERAL DIRECTOR NAME ADDRESS <b>Thomas D. Fletcher Westminister Md. 21157</b>			
25a. DATE REC'D. BY REGISTRAR <b>8-6-1984</b>		25b. REGISTRAR'S SIGNATURE <b>John R. Anderson</b>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 50M 7/77  
(VR A 15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR 1. STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Dorothea B. Hughes		2a. DATE OF DEATH MONTH DAY YEAR August 24 1984 2b. HOUR 4:45 P.M.	
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR May 5 1901 6. AGE (IN YEARS LAST BIRTHDAY) 83 IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH Westminster		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2225 Littlestown Pike		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) school teacher 12b. KIND OF BUSINESS OR INDUSTRY Education	
13a. STATE Md		13b. COUNTY Carroll	
13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2225 Littlestown Pk. 21157		14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Butts	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Cora Emma Page		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	
16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) 220-40-9028		17. INFORMANT ADDRESS James Hughes. New York	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Parkinson's Disease			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) the hospital attended by the deceased from 1978 to 7/26/84, that (I) the deceased alive on 7/26/84, and that in (my) opinion death occurred on the date and hour and from the causes stated above. (I) (did) (did not) view the body after death.		22b. DATE SIGNED 8/25/84	
22c. SIGNATURE Richard Y. Dalrymple		22d. ADDRESS Carroll Plaza, Westminster, Md. 21157	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Richard Y. Dalrymple, M.D.		22f. ADDRESS Carroll Plaza, Westminster, Md. 21157	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/28/84	
23c. NAME OF CEMETERY OR CREMATORY Riverside Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Rochester, Monroe N.Y.	
24. FUNERAL DIRECTOR NAME PRITTS FUND		ADDRESS Westminster, Md.	

AUG 30 1984

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 3 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by telephone.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Isaac Jacobs				8 29 84 12 N M			
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 16 01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Nsg Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy	
14. FATHER'S NAME FIRST MIDDLE LAST Unk				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT ADDRESS Pleasant View Home - Mt. Airy, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Septicemia 2nd to pylonephritis DUE TO, OR AS A CONSEQUENCE OF (c) chronic pylonephritis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (c)							
Alzheimers, Schizophrenia							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/05 19 73 to 8/29 84, that (1) (we) lost saw the deceased alive on 8/23/84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) did (did not) view the body after death.							
22b. SIGNATURE Melvin J Kordon M.D. DEGREE				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/29/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J KORDON M.D.				22e. ADDRESS 2000 Century Plaza Columbia Md. 21044			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-30-84		23c. NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville Carroll Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight				ADDRESS Sykesville Md.		25. DATE OF DEATH AUG 31 1984	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>RAE S. KALKMAN</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-31-84</b>			2b. HOUR <b>1845</b> M				
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>July 26, 1896</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>St. Michaels, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b> MD.				
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. Gen. Hospt.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Md.</b>			13b. CITY OR TOWN <b>Balto.</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS <b>10808 Reisterstown Rd. 21117</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>Ned Butler</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Agnes Jones</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <b>No</b>			16b. SOCIAL SECURITY NO. <b>216-46-5861</b>	
17. INFORMANT ADDRESS <b>Mr. George B. P. Ward Towson, Md.</b>										

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).  
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **CARDIAC ARREST**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last.

(b) **CORONARY INSUFFICIENCY**

DUE TO, OR AS A CONSEQUENCE OF

(c) \_\_\_\_\_

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

**DYSPHAGIA & CACHEXIA**

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-26-84</b> to <b>8-31-84</b> , that (I) (we) last saw the deceased alive on <b>8-31-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>N. Rajpala</b>				DEGREE <b>M.D.</b>		22c. DATE SIGNED <b>8/31/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. RAJPALE</b>				22e. ADDRESS <b>224 Washington Hts Westminster</b>			

23a. BURIAL, CREMATION, REMOVAL (5) <b>Burial</b>		23b. DATE <b>Sept. 4, 84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodlawn Memorial</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Easton Talbot Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>Clive Funeral Home Reisterstown, Md.</b>				25a. DATE REC'D. BY REGISTRAR <b>SEP 4 1984</b>		25b. REGISTRAR'S SIGNATURE <b>S. H. Davidson-Randall</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, regardless of whether the death occurred in the hospital or elsewhere. The law requires that the death certificate be executed within 24 hours after death, regardless of whether the death occurred in the hospital or elsewhere.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.





TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>SARA</b> <b>Keinigham</b>					2a. DATE OF DEATH MONTH <b>8</b> DAY <b>27</b> YEAR <b>84</b> 2b. HOUR <b>6:45 A.M.</b>				
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>Aug.</b> DAY <b>17</b> YEAR <b>1895</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.			
10. CITY OR TOWN OF DEATH <b>Sykesville</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Lake View Domiciliary Care Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a. STATE <b>Md.</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>Oakland Rd. 21784</b>	
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b>Keinigham</b> LAST <b>Keinigham</b>					15. MOTHER'S MAIDEN NAME FIRST <b>Mollie</b> MIDDLE <b>Edward</b> LAST <b>Edward</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>219543182</b>		17. INFORMANT <b>Ruth Minotti</b> ADDRESS <b>Baltimore, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>A.S.C.V.D.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>August 22</b> 19 <b>84</b> to <b>August 27</b> 19 <b>84</b> , that (I) (we) last saw the deceased alive on <b>August 21</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>José L. Chappelle, M.D.</b> DEGREE <b>M.D.</b>					22c. DATE SIGNED <b>8/27/84</b>			22d. ADDRESS <b>6342 Barnett Ave. Sykesville, Md</b>	
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <b>José L. Chappelle, M.D.</b>					22f. ADDRESS <b>6342 Barnett Ave. Sykesville, Md</b>				
23a. BURIAL, CREMATION, REMOVAL (TYPE) <b>Burial</b>			23b. DATE <b>8-28-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Springfield Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Sykesville</b> COUNTY <b>Carroll</b> STATE <b>Md.</b>		
24. FUNERAL DIRECTOR <b>Harry W. Knight</b> ADDRESS <b>Sykesville, Md.</b>					25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <b>Lillian Friedman Rindler</b>		

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>DOROTHY</b>			FIRST MIDDLE LAST <b>KISS</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8 20 84</b>			2b. HOUR <b>4:10</b> <b>A</b>		
3. SEX <b>Female</b>			4. RACE <b>White</b>			5. DATE OF BIRTH MONTH DAY YEAR <b>11 9 18</b>			6. AGE (IN YEARS LAST BIRTHDAY) <b>65</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.		
10. CITY OR TOWN OF DEATH <b>Westminster</b>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hosp.</b>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>seamstress</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>sewing factory</b>		
13a. STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>			13c. CITY OR TOWN <b>Union Bridge</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Carroll E. Hawn</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Ethel Jung</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>none</b>		
16c. ADDRESS <b>216-10-8006</b>			17. INFORMANT <b>Mrs. JoAnn Grinder</b>			17. ADDRESS <b>Union Bridge, MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTEROSCLEROTIC CORONARY VASCULAR DISEASE</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>(this hospital)</del> attended the deceased from <b>AUG 20</b> 19 <b>84</b> , to _____ 19_____, that (I) <del>(lost)</del> saw the deceased alive on <b>AUG 20</b> 19 <b>84</b> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above; (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.											
22b. SIGNATURE <b>Arthur L. Rudo, MD</b>						DEGREE <b>MD</b>			22c. DATE SIGNED <b>8/20/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ARTHUR L. RUDO, M.D.</b>						22e. ADDRESS <b>524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157</b>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8/22/84</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Union Bridge Carroll MD</b>		
24. FUNERAL DIRECTOR NAME <b>D. D. Harbler</b>						ADDRESS <b>Union Bridge, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 22 1984</b>		
25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked by item 18, shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. From the time of death to the time of completion of the certificate, the attending physician must be available to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1- FOR STATE REGISTRAR					REG. NO.				
1 DECEASED NAME (TYPE OR PRINT) <b>Clarence E. Koerner, Sr.</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>8-20-84</b>			2b. HOUR <b>1005 P M</b>	
3 SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH MONTH DAY YEAR <b>8 15 1919</b>		6 AGE (IN YEARS LAST BIRTHDAY) <b>65 YRS.</b>		7 UNDER 1 YEAR MONTHS DAYS <b>65</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co. MD.</b>			
10 CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. Gen'l Hospital</b>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Construction</b>		12b KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE <b>Md.</b> 13b CITY <b>Carroll</b> 13c CITY OR TOWN <b>Hampstead</b> 13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					13e STREET ADDRESS / ZIP CODE <b>2145 Albert Rill Rd. 21074</b>				
14 FATHER'S NAME FIRST MIDDLE LAST <b>Frank Koerner</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Florence Reily</b>				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>yes</b>		(IF YES, GIVE WAR OR DATES) <b>WW2</b>		16b SOCIAL SECURITY NO. <b>213-16-0464</b>		17 INFORMANT ADDRESS <b>Mr. Charles W. Koerner, Hampstead, Md.</b>			
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the tonsil</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>8/18 84</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <b>8/20 84</b>					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/20 84</b> to <b>8/20 84</b> , that (we) lost <b>84</b> above, (I) (we) (did) (did not) view the body after death. <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>John Davidson</b>					DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/20/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-22-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Mem. Gard.</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Finksburg -Carroll Md.</b>			
24 FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Hampstead, Md. 21074</b>					25a. DATE REC'D. BY REGISTRAR <b>AUG 23 1984</b>				

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>VIVIANNE S. LEDDON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-18-84</b>			2b. HOUR <b>1940</b> M			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>10 31 15</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b> MD.			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Co. Gen'l Hospital</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Hwf</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Baltimore</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>503 Murdock Road 21213</b>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Chester B. Streett</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Blanche Delphay</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>				16b. SOCIAL SECURITY NO. <b>215-10-3527</b>		17. INFORMANT ADDRESS <b>Mr. Herbert Moore, Jr., Upperco, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE RESPIRATORY FAILURE</b> 1 HR DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <b>CHRONIC RESPIRATORY FAILURE</b> 1 yr. DUE TO, OR AS A CONSEQUENCE OF (c) <b>SEVERE EMPHYSEMA</b> Few yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. <b>ANGINA</b>									
19a. DATE OF OPERATION <b>8-6-84</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>TRACHEOSTOMY</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-18-84</b> to <b>8-18-84</b> , that (I) (we) lost <b>8-18-84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated									
22b. SIGNATURE <b>N. Rajpara</b>			DEGREE <b>MD</b>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-18-84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>N. RAJPARA</b>			22e. ADDRESS <b>224 WASHINGTON HB. WESTMINSTER</b>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-20-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Moreland Mem. Park</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Baltimore Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home</b>			ADDRESS <b>Hampstead, Md.</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Davidson-Rendell</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called on at once.

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Handwritten notes on lined paper, including a circled number 1 in the top right corner and two punch holes on the right margin. The text is mostly illegible due to blurriness and bleed-through from the reverse side.

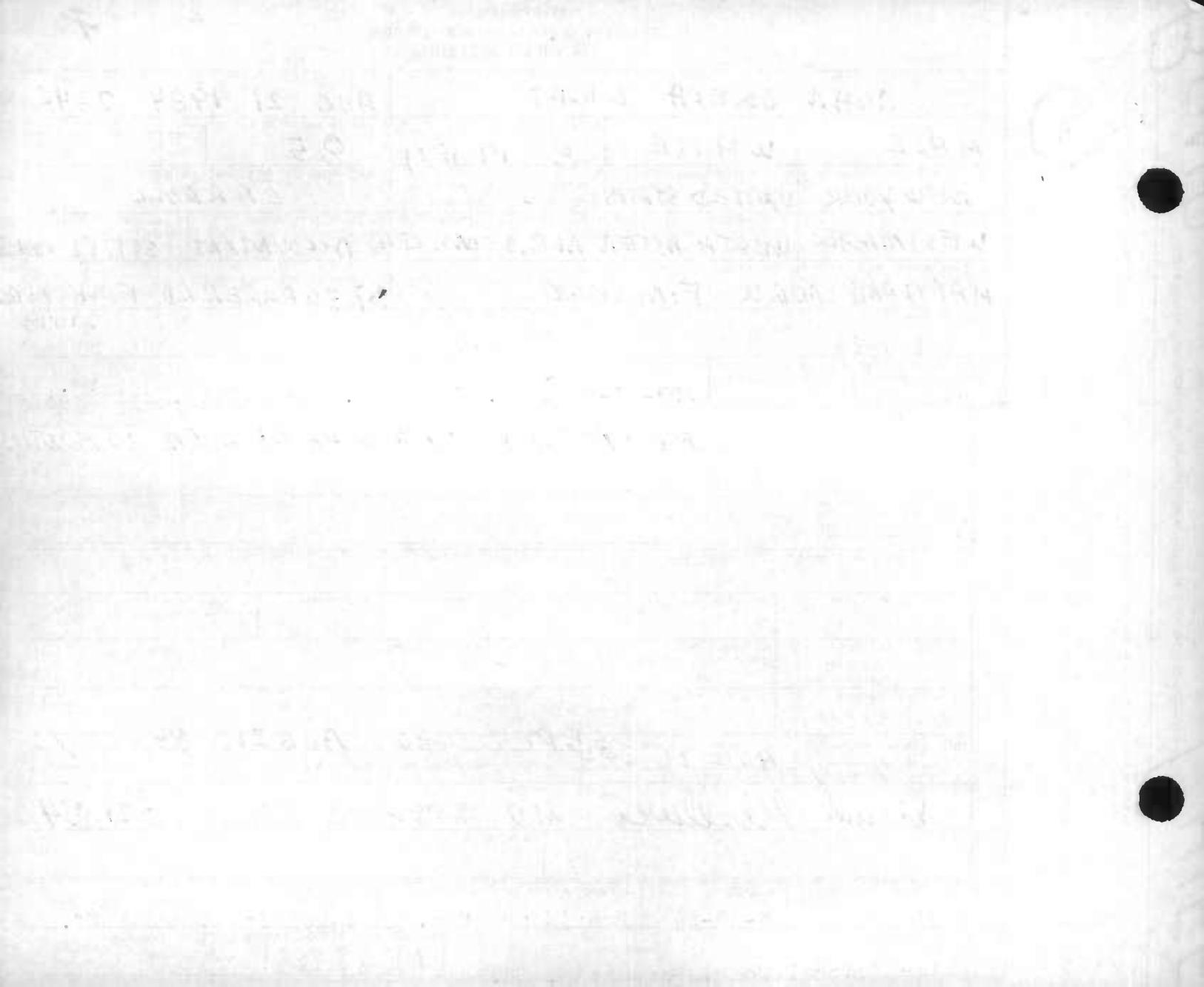


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>JOHN JOSEPH. LIGHT</b>					2a. DATE OF DEATH MONTH <b>AUG</b> DAY <b>21</b> YEAR <b>1984</b>			2b. HOUR <b>2345</b> <sup>M</sup>	
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH MONTH <b>8</b> DAY <b>19</b> YEAR <b>1899</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW YORK</b>		7b. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.			
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>WESTMINSTER NUR. &amp; CONV. CT.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>ACCOUNTANT</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>STEEL MANUFACTURING</b>	
13a. STATE <b>MARYLAND</b>					13b. CITY OR TOWN <b>CARROLL</b>		13c. STREET ADDRESS / ZIP CODE <b>FINKSBURG RD. FINKSBURG MD. 21048</b>		
14. FATHER'S NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>					15. MOTHER'S MAIDEN NAME FIRST <b>Unknown</b> MIDDLE <b></b> LAST <b></b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>no</b>			16b. SOCIAL SECURITY NO. <b>097-07-8896</b>		17. INFORMANT <b>Mr. Thomas F. Stansfield, Westminster Md</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA OF LIVER</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 MONTHS</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b></b>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>SEPT 21 1980</b> to <b>AUG 21 1984</b> , that (I) (we) lost <b>the deceased</b> on <b>AUG 21 1984</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Daniel J. Bellver</b>					DEGREE <b>MD</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8-21-84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-25-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Providence Cem.</b>		23d. LOCATION CITY OR TOWN <b>Finksburg</b> COUNTY <b>Carroll</b> STATE <b>Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Eline Funeral Home, Hampstead, Md.</b> ADDRESS <b></b>					25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>AUG 23 1984</b> <b>Chia Davidson-Randall</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST marion R. Libby						2a. DATE OF DEATH MONTH DAY YEAR 8 31 84		2b. HOUR M	
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 8 10 01		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 32 Carroll St				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) beautician		12b. KIND OF BUSINESS OR INDUSTRY beauty shop	
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 32 Carroll St	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Fritz				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Myerly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) n/a		17. INFORMANT ADDRESS June Libby 13e 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ovarian cancer</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause "a", stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 year</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>8/1</u> , 19 <u>84</u> , to <u>8/1</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Norman Goldstein</u>				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8/4/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Norman Goldstein				22e. ADDRESS 218 Washington Heights Med Ctr Westminster Md					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 9/4/84		23c. NAME OF CEMETERY OR CREMATORY Kriders		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md			
24. FUNERAL DIRECTOR NAME PRITTS FUNERAL HOME				ADDRESS WESTMINSTER MD		25a. DATE REC'D. BY REGISTRAR SEP 14 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR STATE REGISTRAR *Bernie CM*

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Bernie E. Mancha</i>			2a. DATE OF DEATH MONTH DAY YEAR 8 22 1984			2b. HOUR 1035 AM				
3. SEX <i>Female</i>		4. RACE <i>Cal.</i>		5. DATE OF BIRTH MONTH DAY YEAR 4 3 1938		6. AGE (IN YEARS LAST BIRTHDAY) 46 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Silver Run</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.				
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hosp.</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>School Teacher</i>		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Georgia</i>			13b. CITY OR TOWN <i>Lilburn</i>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <i>3306 Alcazar Drive 30247</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Harry Milton Stonesifer</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Catherine Snyder</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>			16b. SOCIAL SECURITY NO. <i>219-34-1295</i>		17. INFORMANT <i>Thomas W. Mancha</i>				17b. ADDRESS <i>3306 Alcazar Drive Lilburn, Georgia 30247</i>	

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART I. DEATH WAS CAUSED BY:

## IMMEDIATE CAUSE (a)

*CARCINOMATOSIS*

## DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) *Carcinoma of Breast*

## DUE TO, OR AS A CONSEQUENCE OF

(c)

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>8-17-84</i> to <i>8-22-84</i> , that (I) (we) lost saw the deceased alive on <i>8-22-84</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Chitra Chudunagana</i>		DEGREE <i>MD</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/22</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>CHITRACHUDUNAGANA</i>		22e. ADDRESS <i>700 A poole Rd. WESTMINSTER MD 21157</i>					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-24-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westminster Cemetery</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Westminster Carroll Md.</i>	
24. FUNERAL DIRECTOR NAME <i>Thomas D. Fletcher &amp; Son</i>				25. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <i>21157</i>			

2501-055-05



2129400000000000

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2501-055-05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked on item 18 show any injury, or other traumatic event, the medical examiner and the medical examiner's report must be attached to this certificate.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 22040			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>Catherine Elizabeth Martin</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8 13 84</b>		2b. HOUR A <b>3:47 M</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>9 19 08</b>		6 AGE (IN YEARS LAST BIRTHDAY) YRS MONTHS DAYS <b>75</b>	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll MD.</b>	
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll Lutheran Health Ctr.</b>		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>	
13a STATE <b>Maryland</b>				13b COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Union Bridge</b>	
14 FATHER'S NAME FIRST MIDDLE LAST <b>Raymond I. Buffington</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Margaret Eyler</b>			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>212-18-3484</b>		17 INFORMANT ADDRESS <b>Ralph Buffington Union Bridge, MD</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARDIOPULMONARY ARREST</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>GRAM NEG sepsis.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>CELLULITIS BUTTOCKS</b> Approximate interval between onset and death: <b>3 MIN.</b> <b>3 DAYS</b> <b>1 MONTH</b>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a I certify that (I) (this hospital) attended the deceased from <b>8/11/84</b> to <b>8/13/84</b> , that (I) (we) lost <b>saw the deceased alive on above date</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above.							
22b. SIGNATURE <b>John E. Smith</b>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/13/84</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/15/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Pipe Creek Cemetery New Windsor Carroll MD</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>near Union Bridge MD 21781</b>	
24 FUNERAL DIRECTOR NAME <b>N. A. Harbler</b>		ADDRESS <b>Union Bridge, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 15 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Felia Davidson-Randall</b>	





1- FOR  
STATE  
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. HOUR		
FIRST MIDDLE LAST JOHN Robert MEREDITH			MONTH DAY YEAR 8 19 84			2b. HOUR 9:50 P.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	7c. DATE PRONOUNCED DEAD		
Male	White	Feb. 26 1946	44 YRS.	MONTHS DAYS HOURS MIN.		8 19 84		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		
Md.		U.S.A.				Carroll County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Sykesville			Rt. 26 at Emerald Lane			Teacher		School
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS		
Md.			Carroll	Sykesville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	11 Obrecht Rd		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Russell A. Meredith				FIRST MIDDLE LAST Anna Mae Clevenger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS		
No						Lucille Meredith Sykesville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a) Multiple injuries								
8120								
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last								
(b)								
DUE TO, OR AS A CONSEQUENCE OF								
(c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
			HOUR MONTH DAY YEAR 8:15 A.M. 8-19- 19 84		Driver in auto/auto collision.			
21d. INJURY OCCURRED			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		21g. COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			road		Rt. 26 at Emerald Lane		Carroll Md.	
22a. I certify that I have charge of the remains described above; held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE			TITLE (SPECIFY)			DATE SIGNED		
Thomas D. Smith			Deputy Chief			8-20-84		
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS					
Thomas D. Smith, M.D.			111 Penn St., Balto., Md.			21201		
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
Burial			8-24-84		Wesley Freedom Cemetery		Sykesville Carroll Md.	
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Name Harry W. Haight			Address Sykesville, Md.			AUG 22 1984 John Davidson-Wendell		

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified of same.

DHMH-16 30M 2/80  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												
1. FOR STATE REGISTRAR		REG. NO.										
I. DECEASED NAME (TYPE OR PRINT)		FIRST Francis		MIDDLE (NMN)		LAST Muller		2a. DATE OF DEATH MONTH DAY YEAR Aug. 2, 1984		2b. HOUR A. 6:30 M.		
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Sept. 4, 1907		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS 10 28		IF UNDER 24 HRS. HOURS MIN. 10 28		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.						
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 203 Lambert Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer-Retired			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 203 Lambert Ave. (21776)		
14. FATHER'S NAME FIRST MIDDLE LAST Henry J. Muller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rachel Wagner								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-36-4867		17. INFORMANT ADDRESS Louise S. Muller, Same As #13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest, ASHD, Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (b) (generalized), Hypertension, Arthritis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (the hospital) attended the deceased from 1960, 19, to 8-2-84, 19, that (I) (we) lost saw the deceased alive on 8-2-84, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.												
22b. SIGNATURE Howard E. Hall		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-3-84						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D., P.A.				22e. ADDRESS PO Box 318, Sykesville, Md. 21784								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-5-1984		23c. NAME OF CEMETERY OR CREMATORY Salem		23d. LOCATION CITY OR TOWN COUNTY STATE Winfield, Carroll, Md.						
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE L. A. Davidson, Randall						

BP

Wee! ————

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Finger-prints may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR					20. DATE OF DEATH MONTH DAY YEAR 2b HOUR						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>DORIS Beverley MYERS</b>					8 4 84					11 <sup>00</sup> A.M.	
3. SEX <b>FEMALE</b>		4. RACE <b>CAUCASIAN</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>11 15 38</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL COUNTY</b> MD.					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL CO. GENERAL</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		
13a. STATE <b>MARYLAND</b>		13b. COUNTY <b>CARROLL</b>		13c. CITY OR TOWN <b>UNION BRIDGE</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>1319 BAUST CHURCH RD 21791</b>			
14. FATHER'S NAME FIRST MIDDLE LAST <b>James Corbin</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Maxine Smith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>					16b. SOCIAL SECURITY NO. <b>214-36-9039</b>		17. INFORMANT ADDRESS <b>Ivan W. Myers 1319 Baust Church Road Union Bridge, MD 21791</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGENITAL TRUNCUS ARTERIOSUS &amp; V.S.D.</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>45 yr.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <u>D</u> (this hospital) attended the deceased from <u>4/22</u> , 19 <u>77</u> , to <u>8/4</u> , 19 <u>84</u> , that (1) <u>we</u> last saw the deceased alive on <u>7/10</u> , 19 <u>84</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above. <u>0</u> (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Wm. R. Linthicum, M.D.</i> 22b. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm. R. LINTHICUM, M.D.</b>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					22c. DATE SIGNED <b>8/4/84</b>	
22d. ADDRESS <b>TANEXTOWN, MARYLAND 21787</b>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>Aug. 7, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Lutheran</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Uniontown, Carroll, Maryland</b>			
24. FUNERAL DIRECTOR NAME <b>Skiles Funeral Home</b>			136 E. Baltimore Ave. ADDRESS <b>Tanextown, MD 21787</b>			25a. DATE REC'D. BY REGISTRAR <b>AUG 8 1984</b>		25b. REGISTRAR'S SIGNATURE <i>J. H. Davidson-Randall</i>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Rebecca L. Myers</b>		2a. DATE OF DEATH MONTH <b>8</b> DAY <b>18</b> YEAR <b>84</b> 2b. HOUR <b>11</b> MIN. <b>30</b> AM	
1. SEX <b>Female</b>	4. RACE <b>Can</b>	5. DATE OF BIRTH MONTH <b>10</b> DAY <b>03</b> YEAR <b>03</b>	6. AGE (IN YEARS LAST BIRTHDAY) <b>80</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.
10. CITY OR TOWN OF DEATH <b>Westminster</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Housewife</b>	12b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>
13a. STATE <b>MD</b>	13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Washington D.C.</b>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST <b>Joseph</b> MIDDLE <b>Hill</b> LAST <b>Hill</b>	15. MOTHER'S MAIDEN NAME FIRST <b>Molly</b> MIDDLE <b>Unknown</b> LAST <b>Unknown</b>	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b> 16b. SOCIAL SECURITY NO. <b>579-72-1556</b>	
17. INFORMANT <b>Dorothy R. Moore</b>		ADDRESS <b>410 Baldwin Park Dr. #T-4 Westminster, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Peritonitis, Sepsis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Perforation Colon x 2</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Obstruction, adenocarcinoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Colon</b>			
19a. DATE OF OPERATION <b>8/11/84</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Perforation Colon</b>	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21e. LOCATION STREET CITY OR TOWN COUNTY STATE		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <b>(the hospital)</b> attended the deceased from <b>8/12</b> 19 <b>84</b> , to <b>8/18</b> 19 <b>84</b> , that (I) <b>(lost)</b> saw the deceased alive on <b>8/18</b> 19 <b>84</b> , and that in (my) <b>(lost)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(did)</b> view the body after death.			
22b. SIGNATURE <b>John E. Steers</b>		22c. DATE SIGNED <b>8/18/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John E. Steers</b>		22e. ADDRESS <b>222 Washington Hts Westminster Md</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8/21/84</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Cemetery</b>		23d. LOCATION CITY OR TOWN <b>Suitland</b> COUNTY <b>P.G.</b> STATE <b>Maryland</b>	
24. FUNERAL DIRECTOR NAME <b>George P. Kalas</b> ADDRESS <b>6160 Oxon Hill Rd. Oxon Hill, Md.</b>		25a. DATE REC'D. BY REGISTRAR <b>AUG 21 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>via Davidson-Randall</b>		25c. REGISTRAR'S SIGNATURE <b>via Davidson-Randall</b>	

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CHARLES W. NELSON</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-26-84</b>		2b. HOUR <b>2:45 PM</b>					
3. SEX <b>M</b>		4. RACE <b>CAUC</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>6 6 10</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>74</b>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md. Annapolis</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>PRINCE GEORGE MD.</b>				
10. CITY OR TOWN OF DEATH <b>HYATTSVILLE</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL MANOR NURSING HOME</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>PRIEST-Roman Catholic</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>(20782)</b>				
13a. STATE <b>MD</b>		13b. COUNTY <b>P. G.</b>		13c. CITY OR TOWN <b>HYATTSVILLE</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>4920 LASALLE RD.</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>CHARLES NELSON</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>MARGARET CLUNEY</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <b>NO -</b>						
16b. SOCIAL SECURITY NO. <b>156-30-2116</b>		17. INFORMANT ADDRESS <b>THOMAS DUFFY 6001 WILSON AVENUE WASH. D.C.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>ATHEROSCLEROTIC DISEASE</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) <b>HYPERTENSION</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>10 YRS.</b> <b>10 YRS.</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>8/26</b> , 19 <b>84</b> , to <b>8/26</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>8/26</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Kevin G. Nealon</b>						DEGREE <b>M.D.</b> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>8/26/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>KEVIN G. NEALON M.D.</b>						22e. ADDRESS <b>916 19TH ST. N.W. WASH. D.C.</b>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>			23b. DATE <b>8-29-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION CITY OR TOWN COUNTY STATE <b>Silver Spring Mont. Md.</b>		
24. FUNERAL DIRECTOR NAME <b>Nalley's F.H. Inc. Mt. Rainier, Md.</b>						25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE <b>SEP 04 1984 Julia Davidson-Randall</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-burial papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) JOHN William NEWTON					2a. DATE OF DEATH MONTH DAY YEAR 8-25-84					2b. HOUR 1330 M
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 12 96		6. AGE (IN YEARS (LAST BIRTHDAY)) 87 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cecil Co. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 60 Westmoreland Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Self-Employed Salesman		12b. KIND OF BUSINESS OR INDUSTRY Agriculture		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 60 Westmoreland Street			
14. FATHER'S NAME FIRST MIDDLE LAST John William Newton					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Bramble					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWI		17. INFORMANT 60 Westmoreland St Westminster, Md. 21157 Catherine Haines Newton						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic carcinoma Liver</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Arteriosclerotic Heart disease</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>6-28-</u> 19 <u>84</u> to <u>7-11-</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8/21</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <u>Chitrachudun Aganna</u>					DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/27/84</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHUDUN AGANNA					22e. ADDRESS 700 A poole Rd Medical Centre Westminster MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-28-84		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch Cemetery Westminster Carroll		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster MD				
24. FUNERAL DIRECTOR <u>Thomas D. Fletcher &amp; Son P.F.F.</u> 254 East Main St. Westminster, Md. AUG 29 1984 <u>John Davidson-Randall</u>										

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <i>Myrtle</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>8 23 84</i>			2b. HOUR <i>8e</i> M			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 25 93</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>91</i> YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Texas, Md.</i>		7c. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD			
10. CITY OR TOWN OF DEATH <i>Westminster</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>2722 Valley View Ct.</i>				12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <i>MD</i>		13b. COUNTY <i>Carroll</i>		13c. CITY OR TOWN <i>Westminster</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1634 Gablehammer Rd.</i>	
14. FATHER'S NAME FIRST MIDDLE <i>Samuel Baker</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE <i>Lula Estelle Niekirk</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>216-05-4331</i>		17. INFORMANT ADDRESS <i>Clark Himes 7306 Park Dr. Baltimore Md. 21234</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/22</i> 19 <i>84</i> , to <i>8/23</i> 19 <i>84</i> , that (I) (we) last saw the deceased alive on <i>8/22</i> 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Norman Goldstein</i>				DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED <i>8/23/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Norman Goldstein</i>				22e. ADDRESS <i>218 Washington Heights Medical Center Westminster Md 21157</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>8-25-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Memorial Pk.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore City Md.</i>			
24. FUNERAL DIRECTOR'S NAME <i>Thomas D. Fletcher</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 27 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			



San Francisco, California

Name	Address	City	State
John Doe	123 Main St	San Francisco	California
Jane Smith	456 Oak St	San Francisco	California
Bob Johnson	789 Pine St	San Francisco	California

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked "Other", it is necessary to know any injury, or other traumatic event, the medical examiner must be notified at once.

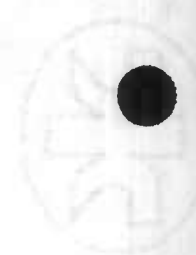
## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARGARET ELIZABETH OHLER				2a. DATE OF DEATH MONTH DAY YEAR 8 2 84		2b. HOUR 2:19 PM	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR April 27, 1906		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 78	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housekeeper		12b. KIND OF BUSINESS OR INDUSTRY Domestic	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Albert		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Curfman		16. STREET ADDRESS 29 E. Baltimore St. 21787			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-18-1749		17. INFORMANT William Baker		R # 1, Box 116 Ortanna, PA 17353	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PARKINSON'S DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YRS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from JUNE 21, 1984, to AUG 2, 1984, that (I) (we) last saw the deceased alive on AUG 2, 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Arthur L Rudo, MD		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/2/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L RUDO, MD		22e. ADDRESS 524 B BALTIMORE BLVD WESTMINSTER, MD. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 6, 1984		23c. NAME OF CEMETERY OR CREMATORY Grace U.C.C. Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Taneytown, Carroll, Maryland	
24. FUNERAL DIRECTOR NAME Skiles Funeral Home		136 E. Baltimore St. Taneytown, MD 21787		25a. DATE REC'D. BY REGISTRAR AUG - 8 1984		25b. REGISTRAR'S SIGNATURE John Davidson-R...	

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 20. *Handwritten text, mostly illegible due to bleed-through.*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 and 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
FOR 1. REGISTRAR										
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADELAIDE C. PETERS					2a. DATE OF DEATH MONTH DAY YEAR August 30, 1984			2b. HOUR 10:15 P		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR September 18, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2401 Carrollton Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk		12b. KIND OF BUSINESS OR INDUSTRY Railroad		
13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 2401 Carrollton Road 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Daniel Clifford Crook				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen C. Carry						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 705-10-5181		17. INFORMANT Ferdinand Peters Same as # 13					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARCINOMA OF COLON-METASTATIC</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 MONTHS</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a.										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) <del>(the hospital)</del> attended the deceased from <u>JULY 9</u> , 19 <u>81</u> , to <u>AUG 30</u> , 19 <u>84</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>AUGUST 28</u> , 19 <u>84</u> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <u>(did not)</u> view the body after death.										
22b. SIGNATURE <u>Arthur L. Rudo MD</u>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 8/31/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Arthur L. Rudo M.D.,			22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER, MARYLAND 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/4/84		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.			
24. FUNERAL DIRECTOR Leroy M. & Russell C. Witzke Funeral Homes P.A. 1630 Edmondson Avenue, Catonsville, Md. 21228										
25a. DATE REC'D. BY REGISTRAR SEP 4 1984					25b. REGISTRAR'S SIGNATURE <u>Sheila Harrison-Randall</u>					



RECEIVED

FOX COLLEGE

PAID BY 3/27/12 C. V. 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or checked, it should be signed by the medical examiner, or other person authorized to sign, and the medical examiner must be notified.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR			
1. DECEASED NAME FIRST MIDDLE LAST CARROLL Bell Phillips				August 14, 1984 6 A. M.			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 5, 1899		6. AGE YEARS LAST BIRTHDAY MONTHS DAYS 85 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5876 Mineral Hill Rd		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Driver		12b. KIND OF BUSINESS OR INDUSTRY Gas + Electric 21784	
13a. STATE Md.		13b. COUNTY CARROLL		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Phillips		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Grace Bell		13e. STREET ADDRESS 5876 Mineral Hill Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212 07 6219		17. INFORMANT ADDRESS Louise Phillips Sykesville, Md.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Inoperable carcinoma of the bowel with</u> DUE TO, OR AS A CONSEQUENCE OF <u>obstruction.</u> (b) <u>Generalized metastasis, arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF <u>generalized</u> (c) <u>Cerebral sclerosis, cachexia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1968 to 8-14-83
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1968, 19, to 8-14, 1984, that (I) (we) lost saw the deceased alive on 8-14-84, 19, and that (I) (my) (our) opinion of death occurred on the date and hour and from the causes stated above. (If (we) did) did not view the body after death.							
22b. SIGNATURE Howard E. Hall				DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-14-84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D.				22e. ADDRESS P.O. Box 318 Sykesville, Maryland 21784			
23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial		23b. DATE 8-17-84		23c. NAME OF CEMETERY OR CREMATORY New Oakland Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Sykesville, Carroll Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight Sykesville, Md.				25. DATE FILED IN DEPARTMENT OF HEALTH AND MENTAL HYGIENE AUG 15 1984			

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STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

FOR  
1 - STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>ADA Belle PRICE</b>			2a. DATE OF DEATH MONTH <b>8</b> DAY <b>18</b> YEAR <b>84</b>			2b. HOUR <b>11:35</b> M	
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH <b>6</b> DAY <b>15</b> YEAR <b>02</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>82</b> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Tennessee</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Carroll County General Hospital</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Taneytown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST <b>Benjamin</b> MIDDLE LAST <b>Denny</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Cora</b> MIDDLE LAST <b>Reese</b>		13e. STREET ADDRESS <b>4300 Harney Road 21787</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. <b>195-26-1676</b>		17. INFORMANT <b>Cecil C. Price R#2, Fairfield, PA 17320</b>			

## 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

## PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Carcinomatosis**

## DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the  
underlying cause last

(b) **Carcinoma Colon**

## DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL  
BETWEEN ONSET AND DEATH  
**months**

## PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

## MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <b>8/7/84</b> to <b>8/18/84</b> , that (I) <del>lost</del> saw the deceased alive on <b>8/18</b> , 19 <b>84</b> , and that in (my) <del>own</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>will</del> (did) <del>not</del> view the body after death.							
22b. SIGNATURE <b>John E. Steers</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/18/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>John E. Steers</b>				22e. ADDRESS <b>222 Washington Hg Westminster</b>			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>Aug. 22, 1984</b>		23c. <del>Sunrise</del> METEMORY OR CREMATORY <b>Sunrise Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Mountain City, Johnson, TN</b>	
24. FUNERAL DIRECTOR NAME <b>Skiles Funeral Home</b>				136 E. Baltimore St. Taneytown, MD 21787		25a. DATE REC'D. BY REGISTRAR <b>Aug 22 1984</b>	
25b. REGISTRAR'S SIGNATURE <b>John E. Steers</b>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



John

John

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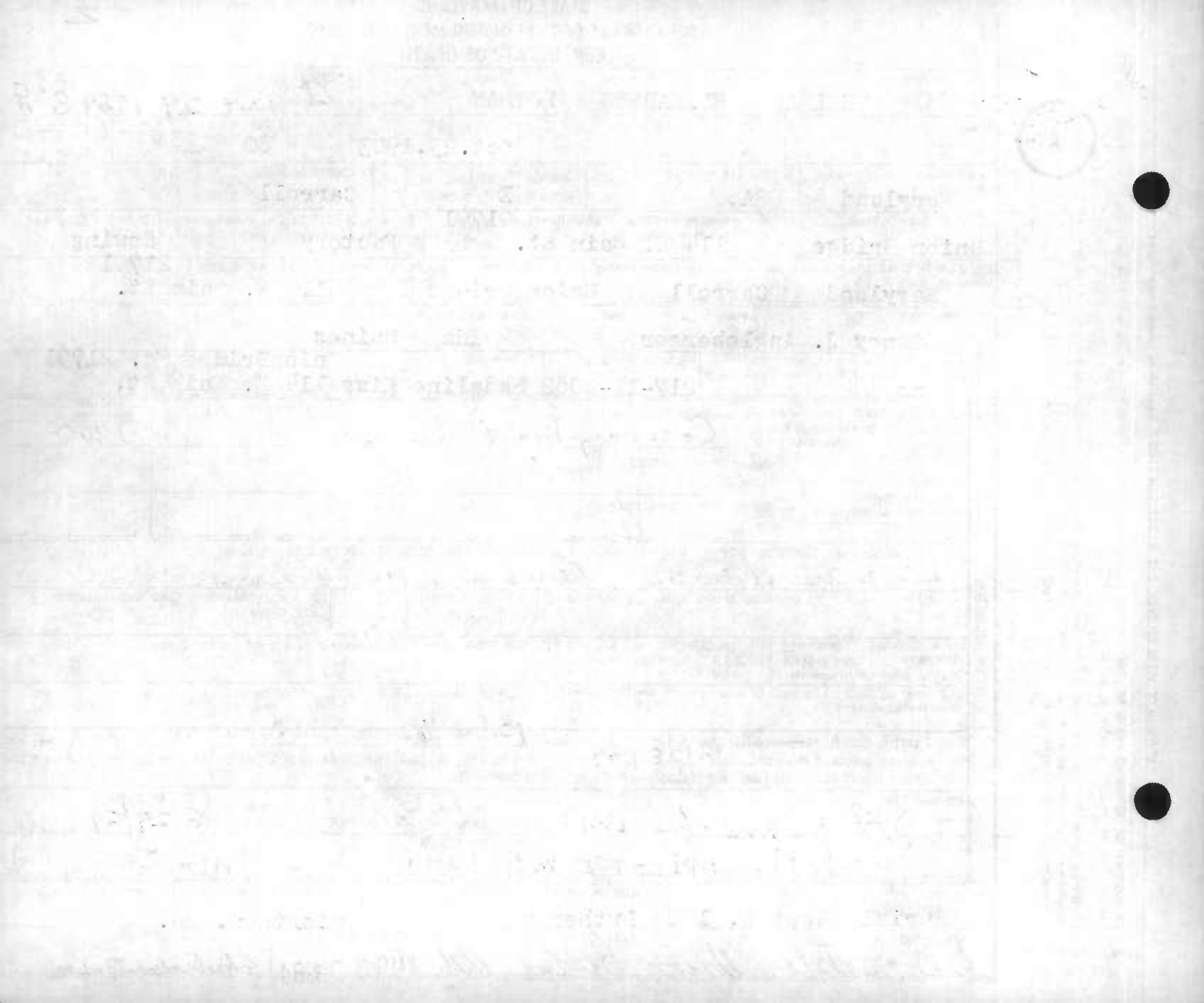
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH - 16 3/72 25M  
(VR A15 (4))

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>THELMA ELIZABETH PUTMAN</b>			2a. DATE OF DEATH Month <u>August</u> Day <u>29</u> Year <u>1984</u>			2b. HOUR <u>8:45</u> M				
3. SEX <b>F</b>		4. RACE <b>W</b>		5. DATE OF BIRTH <b>Oct. 25, 1903</b>		6. AGE (In years last birthday) <b>80</b> YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Carroll</b> Md.				
10. CITY OR TOWN OF DEATH <b>Union Bridge</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>114 N. Main St.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Factory</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Sewing</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Union Bridge</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>21791 114 N. Main St.</b>	
14. FATHER'S NAME First Middle Last <b>Sidney J. Angleberger</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida Haines</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>			16b. SOCIAL SECURITY NO. <b>217-12-2062</b>		17. INFORMANT <b>Union Bridge Md. 21791</b> <b>Madaline Kiss 114 N. Main St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary heart disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1960</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus; Cerebral atherosclerosis</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>12/14/62</u> , 19 <u>62</u> , to <u>Nov</u> , 19 <u>84</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>8/28/84</u> , 19 <u>84</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) (did) ( <del>did not</del> ) view the body after death.										
22b. SIGNATURE <b>J. H. Caricofe MD</b> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED <b>8/29/84</b>					
22d. PHYSICIAN'S NAME (Type) <b>J. H. CARICOFE MD</b>					22e. ADDRESS <b>104 N. Main Union Bridge Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Sept 1, 1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lutheran</b>			23d. LOCATION (City or Town) (County) (State) <b>Uniontown, Md.</b>			
24. FUNERAL DIRECTOR <b>D. D. Hartzler Union Bridge Md</b> ADDRESS					25a. REC'D BY REGISTRAR <b>11630</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>			



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mark Joblin Ripley			2a. DATE OF DEATH MONTH DAY YEAR August 30, 1984			2b. HOUR 0434M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR December 17 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Castle, Va.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 62 Chase Street 21157	
14. FATHER'S NAME FIRST MIDDLE LAST Paul E. Ripley				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Virginia Dasher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 219-12-0746		17. INFORMANT 62 Chase Street Margaret Flohr Ripley Westminster Md. 21157					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ATHEROSCLEROTIC HEART DISEASE</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>None</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 29</u> , 19 <u>84</u> , to <u>Aug 30</u> , 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>Aug 30</u> , 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>John S. Harshey, M.D.</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> STAFF				22c. DATE SIGNED 8/30/84	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSHEY, M.D.				22e. ADDRESS 8 Anchor St. Westminster, Md. 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-1-84		23c. NAME OF CEMETERY OR CREMATORY Kriders Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.			
24. FUNERAL DIRECTOR NAME <u>Thomas D. Fletcher &amp; Son</u>		25. DATE REC'D. BY REGISTRAR SEP 04 1984		25b. REGISTRAR'S SIGNATURE <u>John Davidson-Rodell</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-copy. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

BP

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST		08 08 84		1030 M	
2. SEX		3. RACE		4. DATE OF BIRTH		5. AGE (IN YEARS LAST BIRTHDAY)	
F		W		MONTH DAY YEAR		95 YRS.	
6. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Md		USA				CARROLL MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Westminster Nursing		Homemaker		Home	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Md		CARROLL		Westminster		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
FIRST MIDDLE LAST		FIRST MIDDLE LAST		770		77075 217-28-5675	
KINSEY R		TAYLOR		17. INFORMANT		ADDRESS	
				DORIS SWEISER		640 Gist Rd 21157	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
		Congestive Heart Failure		ASCVD		3 mos	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF		(c)	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 81, to 8-6, 19 84, that (I) (we) last saw the deceased alive on 5-6, 19 84, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
Alva S. Baker				8-7-84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
Alva S. Baker		218 Wash Hts Mod Ctr Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		8-10-84		Carrollton		Westminster Carroll Md	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert Kay Smith Jr.		Westminster, Md		AUG 17 1984		Julia Davidson-Randall	

MEDICAL CERTIFICATION



4

BOX 100101



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified on page 3.

BP

DHMH - 16 50M 4/83  
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 22055							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR	
DELA VIRGINIA SHIPLEY				8-29-84				9P M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
FEMALE		CAUC.		11 19 93		90 YRS.		MONTHS DAYS HOURS MIN.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
MARYLAND		U.S.A.				CARROLL. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
WESTMINSTER		WNCC				Housewife		--	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE	
MARYLAND		BALTIMORE		REISTERSTOWN				21136 512 Berryman's Lane	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
LEONARD WRIGHT				MARGARET TENNY					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
NO		218-40-1954		Vernon Randall		116 Danbury Rd. Reisterstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CEREBROVASCULAR INSUFFICIENCY</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASPIRATION PNEUMONIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to <u>8/29/84</u> 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>RENZO RICCI MD</u>				DEGREE <u>MD</u>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/29/84</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RENZO RICCI MD</u>				22e. ADDRESS <u>3125 BALTIMORE BLVD, FUNKSBURG, MD</u>					
23a. BURIAL, CREMATION, REMOVAL (CHECK BY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		Sept 1, 1984		Reisterstown U.M. Cem.		Reisterstown Balto, Md			
24. FUNERAL DIRECTOR NAME <u>H. S. Schmitt</u> ADDRESS <u>Owings Mills, Md</u>				25a. DATE REC'D. BY REGISTRAR <u>SEP 04 1984</u>		25b. REGISTRAR'S SIGNATURE <u>John W. ...</u>			

HEBER

DOWN

11500 ft. 12000 ft. 13000 ft. 14000 ft. 15000 ft. 16000 ft. 17000 ft. 18000 ft. 19000 ft. 20000 ft. 21000 ft. 22000 ft. 23000 ft. 24000 ft. 25000 ft. 26000 ft. 27000 ft. 28000 ft. 29000 ft. 30000 ft. 31000 ft. 32000 ft. 33000 ft. 34000 ft. 35000 ft. 36000 ft. 37000 ft. 38000 ft. 39000 ft. 40000 ft. 41000 ft. 42000 ft. 43000 ft. 44000 ft. 45000 ft. 46000 ft. 47000 ft. 48000 ft. 49000 ft. 50000 ft. 51000 ft. 52000 ft. 53000 ft. 54000 ft. 55000 ft. 56000 ft. 57000 ft. 58000 ft. 59000 ft. 60000 ft. 61000 ft. 62000 ft. 63000 ft. 64000 ft. 65000 ft. 66000 ft. 67000 ft. 68000 ft. 69000 ft. 70000 ft. 71000 ft. 72000 ft. 73000 ft. 74000 ft. 75000 ft. 76000 ft. 77000 ft. 78000 ft. 79000 ft. 80000 ft. 81000 ft. 82000 ft. 83000 ft. 84000 ft. 85000 ft. 86000 ft. 87000 ft. 88000 ft. 89000 ft. 90000 ft. 91000 ft. 92000 ft. 93000 ft. 94000 ft. 95000 ft. 96000 ft. 97000 ft. 98000 ft. 99000 ft. 100000 ft.

101000 ft. 102000 ft. 103000 ft. 104000 ft. 105000 ft. 106000 ft. 107000 ft. 108000 ft. 109000 ft. 110000 ft. 111000 ft. 112000 ft. 113000 ft. 114000 ft. 115000 ft. 116000 ft. 117000 ft. 118000 ft. 119000 ft. 120000 ft. 121000 ft. 122000 ft. 123000 ft. 124000 ft. 125000 ft. 126000 ft. 127000 ft. 128000 ft. 129000 ft. 130000 ft. 131000 ft. 132000 ft. 133000 ft. 134000 ft. 135000 ft. 136000 ft. 137000 ft. 138000 ft. 139000 ft. 140000 ft. 141000 ft. 142000 ft. 143000 ft. 144000 ft. 145000 ft. 146000 ft. 147000 ft. 148000 ft. 149000 ft. 150000 ft. 151000 ft. 152000 ft. 153000 ft. 154000 ft. 155000 ft. 156000 ft. 157000 ft. 158000 ft. 159000 ft. 160000 ft. 161000 ft. 162000 ft. 163000 ft. 164000 ft. 165000 ft. 166000 ft. 167000 ft. 168000 ft. 169000 ft. 170000 ft. 171000 ft. 172000 ft. 173000 ft. 174000 ft. 175000 ft. 176000 ft. 177000 ft. 178000 ft. 179000 ft. 180000 ft. 181000 ft. 182000 ft. 183000 ft. 184000 ft. 185000 ft. 186000 ft. 187000 ft. 188000 ft. 189000 ft. 190000 ft. 191000 ft. 192000 ft. 193000 ft. 194000 ft. 195000 ft. 196000 ft. 197000 ft. 198000 ft. 199000 ft. 200000 ft.

201000 ft. 202000 ft. 203000 ft. 204000 ft. 205000 ft. 206000 ft. 207000 ft. 208000 ft. 209000 ft. 210000 ft. 211000 ft. 212000 ft. 213000 ft. 214000 ft. 215000 ft. 216000 ft. 217000 ft. 218000 ft. 219000 ft. 220000 ft. 221000 ft. 222000 ft. 223000 ft. 224000 ft. 225000 ft. 226000 ft. 227000 ft. 228000 ft. 229000 ft. 230000 ft. 231000 ft. 232000 ft. 233000 ft. 234000 ft. 235000 ft. 236000 ft. 237000 ft. 238000 ft. 239000 ft. 240000 ft. 241000 ft. 242000 ft. 243000 ft. 244000 ft. 245000 ft. 246000 ft. 247000 ft. 248000 ft. 249000 ft. 250000 ft. 251000 ft. 252000 ft. 253000 ft. 254000 ft. 255000 ft. 256000 ft. 257000 ft. 258000 ft. 259000 ft. 260000 ft. 261000 ft. 262000 ft. 263000 ft. 264000 ft. 265000 ft. 266000 ft. 267000 ft. 268000 ft. 269000 ft. 270000 ft. 271000 ft. 272000 ft. 273000 ft. 274000 ft. 275000 ft. 276000 ft. 277000 ft. 278000 ft. 279000 ft. 280000 ft. 281000 ft. 282000 ft. 283000 ft. 284000 ft. 285000 ft. 286000 ft. 287000 ft. 288000 ft. 289000 ft. 290000 ft. 291000 ft. 292000 ft. 293000 ft. 294000 ft. 295000 ft. 296000 ft. 297000 ft. 298000 ft. 299000 ft. 300000 ft.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17  
(VR A15 ME (5))  
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) <b>Thomas Eldridge</b>										2a. DATE KNOWN OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>1984</b> HOUR <b>11:45</b> AM	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>11</b> DAY <b>25</b> YEAR <b>1904</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>79</b> YRS.		7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>11</b> YEAR <b>1984</b> HOUR <b>11:45</b> AM		7b. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Carroll County</b>				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll</b> MD.	
10. CITY OR TOWN OF DEATH <b>Sykesville</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>1100 Powder Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Watchman</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Balt. City Reservoir</b>	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <b>1100 Powder Rd. 21784</b>			
14. FATHER'S NAME FIRST <b>Brice</b> MIDDLE <b>McHenry</b> LAST <b>Shipley</b>						15. MOTHER'S MAIDEN NAME FIRST <b>Emma</b> MIDDLE <b>Deckabaugh</b> LAST <b>Deckabaugh</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>No</b>				16b. SOCIAL SECURITY NO. <b>219-14-7640</b>		17. INFORMANT ADDRESS (same above) <b>Mary Catherine Shipley</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Guns shot wound</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Richard Jones</b>						TITLE (SPECIFY) <b>Deputy</b>		M.D.		MEDICAL EXAMINER <b>Westminster</b>	
EXAMINER'S NAME (TYPE OR PRINT) <b>Richard Jones</b>						ADDRESS		DATE SIGNED <b>11 Aug 84</b>		INITIALS <b>ML</b>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8-14-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Westminster</b> COUNTY <b>Carroll</b> STATE <b>MD.</b>	
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher &amp; Son</b> ADDRESS <b>254 East Main Street Westminster, Maryland</b>						25a. DATE REC'D. BY REGISTRAR <b>AUG 24 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			



*[Faint, mostly illegible text and markings covering the page, including a large circular stamp in the bottom center.]*

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <b>Miriam E. Small</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>8-17-84</b>		2b. HOUR <b>6:55 PM</b>
3. SEX <b>Female</b>	4. RACE <b>Caucasian</b>	5. DATE OF BIRTH MONTH DAY YEAR <b>11 25 86</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>97</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co.</b> MD.	
10. CITY OR TOWN OF DEATH <b>Sikesville</b>	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairhaven Facility</b>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>
13a. STATE <b>md</b>		13b. COUNTY <b>Carroll</b>	13c. CITY OR TOWN <b>Sikesville</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <b>Richard C. Williams</b>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mariam E. Hammond</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR "UNKNOWN") <b>NO</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE DATE) <b>201-30 6623</b>		17. INFORMANT <b>Residents Chart</b>	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

**CONGESTIVE HEART FAILURE**

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) **ARTERIO SCLEROTIC CARDIOVASCULAR DISEASE**

DUE TO, OR AS A CONSEQUENCE OF

(c)

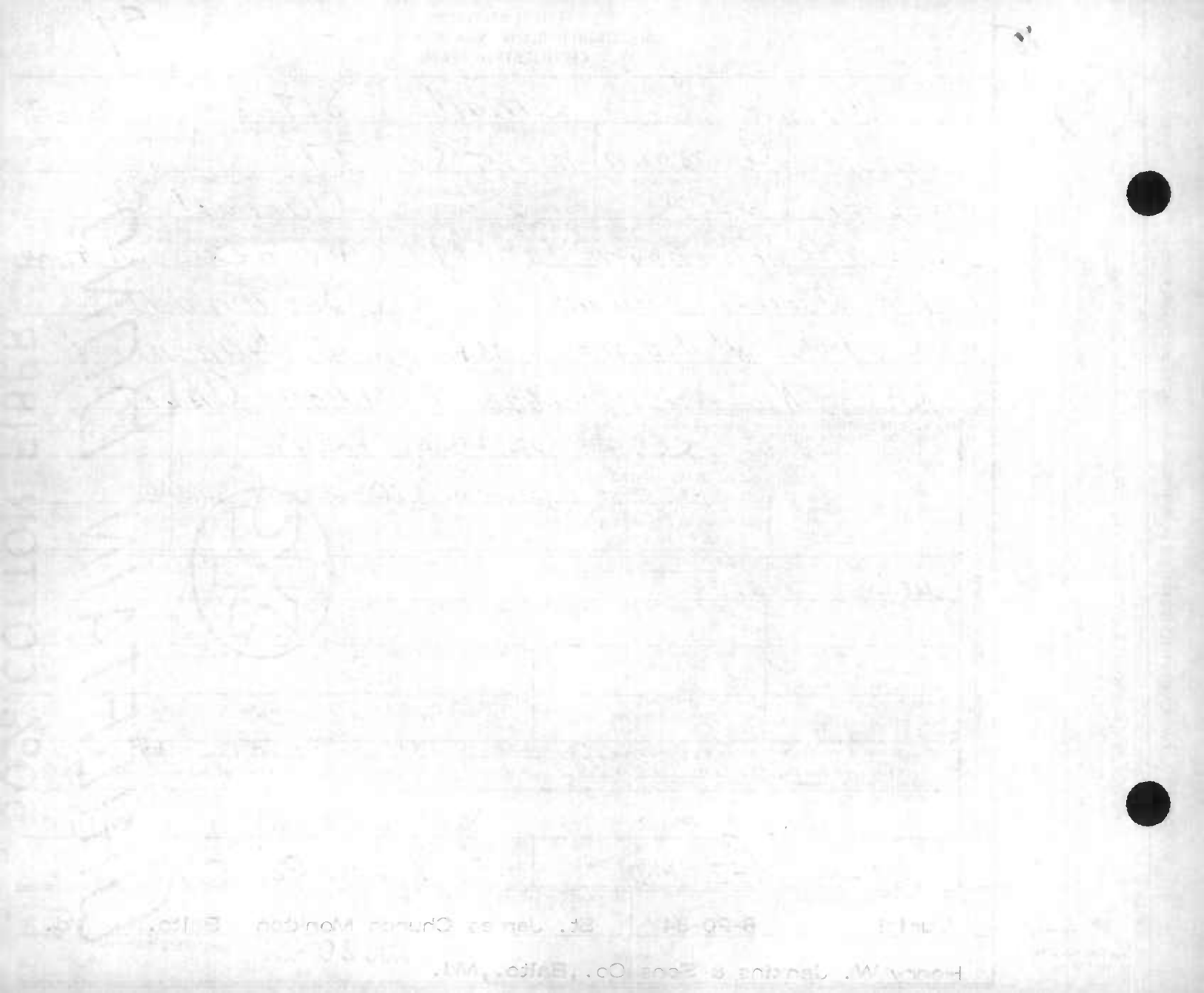
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**HERPES ZOSTER**

MEDICAL CERTIFICATION

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <b>December 21, 19 81</b> , to <b>August 17, 19 84</b> , that (I) (we) lost saw the deceased alive on <b>August 17, 19 84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <b>Ellis Mez MD</b>	DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <b>8/17/84</b>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>ELLIS MEZ MD</b>		22e. ADDRESS <b>1425 Liberty Rd. Elkhurst MD</b>	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>	23b. DATE <b>8-20-84</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. James Church</b>	23d. LOCATION CITY OR TOWN COUNTY STATE <b>Balto. Md.</b>
24. FUNERAL DIRECTOR NAME ADDRESS <b>Henry W. Jenkins &amp; Sons Co., Balto., Md.</b>		25a. DATE OF REGISTRATION <b>AUG 20 1984</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified at once.

## MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR <i>Erna F</i>				2a. DATE OF DEATH MONTH <i>8</i> DAY <i>8</i> YEAR <i>1984</i> 2b. HOUR <i>5:4 M</i>			
1. DECEASED NAME FIRST MIDDLE LAST <i>Erna F Sorensen</i>				3. SEX <i>F</i> 4. RACE <i>W</i> 5. DATE OF BIRTH MONTH <i>8</i> DAY <i>20</i> YEAR <i>91</i>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>DENMARK</i>				7b. CITIZEN OF WHAT COUNTRY? <i>US</i>			
10. CITY OR TOWN OF DEATH <i>Sykesville CARROLL CT.</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION <i>FAIR HAVEN Nursing Home</i>			
13a. STATE <i>md</i> 13b. COUNTY <i>MD</i> 13c. CITY OR TOWN <i>Balto</i>				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS <i>524 N. Charles Street</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>Niels M. Petersen</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Marie F. Vinberg</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>				16b. SOCIAL SECURITY NO. <i>212-10-9058</i>			
17. INFORMANT ADDRESS <i>1421 Woodcliff Ave. - Balto., Md.</i>				17. INFORMANT <i>Emily S. Sauerwein</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>9/22</i> , 19 <i>81</i> , to <i>8/8</i> , 19 <i>84</i> , that (I) (we) lost saw the deceased alive on <i>8/8</i> , 19 <i>84</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Patrick A. Turner</i> DEGREE <i>MD</i>				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/8/84</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>PATRICK A. TURNER</i>				22e. ADDRESS <i>7200 THIRD AVE SYKESVILLE, MD 21784</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>		23b. DATE <i>8-13-84</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Westview Mem. Pk. Cem.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>Balto. MD.</i>	
24. FUNERAL DIRECTOR NAME <i>G. Truman Schwab</i>				25a. DATE REC'D. BY REGISTRAR <i>AUG 13 1984</i>		25b. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

RECEIVED  
JAN 10 1964

1

RECEIVED  
JAN 10 1964

RECEIVED  
JAN 10 1964

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Edna				Spurrier	8		29	84	11:30		AM
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female	Cauc		9 19 09		74 YRS.		11 10		HOURS		MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	USA				Carroll County MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Mt Airy	Pleasant View Nursing Home		Clerk								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS					
13a. STATE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS					
Maryland						Park Ave. (21771)					
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
Jesse				Mary		Agnes Weishaar					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
No				215-03-6111A		1522 Glen Keith Blvd M. Eugene Spurrier, Balto., Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <u>acute pulmonary edema 2nd prob MI</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>General Atherosclerosis</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Alzheimers, ulcers decubital</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from <u>11/9/82</u> 19 <u>82</u> , to <u>8/29/84</u> 19 <u>84</u> , that (1) (we) lost saw the deceased alive on <u>8/23/84</u> 19 <u>84</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.											
22b. SIGNATURE <u>Michael J. Kordon</u> DEGREE											22c. DATE SIGNED <u>8/29/84</u>
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael J. Kordon</u>											22e. ADDRESS <u>2000 Century Plaza Columbia Md 21046</u>
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Burial		8-31-1984		Marvin Chapel		Frederick		Md.			
24. FUNERAL DIRECTOR NAME ADDRESS <u>Charles W. Burrier, Jr., Sykesville, Md.</u>											

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

Charles W. Burrier, Jr., Sykesville, Md.

Burial 8-31-1984 Marvin Chapel

Redford, Md.

Charles W. Burrier, Jr., Sykesville, Md.  
Burial 8-31-1984 Marvin Chapel

Charles W. Burrier, Jr., Sykesville, Md.  
Burial 8-31-1984 Marvin Chapel

Charles W. Burrier, Jr., Sykesville, Md.  
Burial 8-31-1984 Marvin Chapel

Charles W. Burrier, Jr., Sykesville, Md.  
Burial 8-31-1984 Marvin Chapel

Charles W. Burrier, Jr., Sykesville, Md.  
Burial 8-31-1984 Marvin Chapel

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <b>CARRIE STIMAX</b>			2a. DATE OF DEATH MONTH DAY YEAR <b>Aug 6 1984</b>		2b. HOUR <b>9 AM</b>			
3. SEX <b>Female</b>		4. RACE <b>Cauc</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>May 8 1891</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>93</b> YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.		
10. CITY OR TOWN OF DEATH <b>Manchester</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Long View Nursing Home</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>—</b>		
12b. KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Md.</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Westminster</b>		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE <b>79 John St. Westminster</b>		13f. ZIP CODE <b>21157</b>				
14. FATHER'S NAME FIRST MIDDLE LAST <b>Charles Niden</b>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Anna Barnes</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>212-14-6413</b>		17. INFORMANT <b>Sylvia M. Welch.</b>			ADDRESS	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic Cardiovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>—</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>—</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <b>Senile Dementia</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 yrs</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>— P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <b>3/19</b> 19 <b>80</b> , to <b>Aug 6</b> 19 <b>84</b> , that (I) (we) lost the deceased alive on <b>7/17/84</b> 19 <b>—</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <b>W H FORD MD</b>				DEGREE <b>MD</b>		22c. DATE SIGNED <b>8/6/84</b>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>W H FORD MD</b>				22e. ADDRESS <b>3223 Main St Manchester Md 21102</b>				
23a. BURIAL, CREMATION, REMOVAL <b>Burial</b>		23b. DATE <b>8-9-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Trinity</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Westminster Carroll Md</b>		
24. FUNERAL DIRECTOR NAME <b>Kyle Potts</b>				24b. REGISTRAR'S SIGNATURE <b>John Anderson-Randall</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Physicians be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.)

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR 1. DECEASED NAME (TYPE OR PRINT) <b>Lillian R SUTTON</b>						2a. DATE OF DEATH MONTH DAY YEAR <b>8 19 84</b>		2b. HOUR <b>2 P M</b>			
3. SEX <b>Female</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>02 16 1935</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>89</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NEW JERSEY.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD					
10. CITY OR TOWN OF DEATH <b>WESTMINSTER</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>West Nursing convalescent Center.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>N. J.</b>		13b. CITY OR TOWN <b>Hunterdon</b>		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS / ZIP CODE <b>Academy Street 07830</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>Christopher Hildebrant</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Mary M. Henderson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>none</b>		17. INFORMATION ADDRESS <b>R.R.1 Box 80-A Ross Sutton, Jr. Stewartsville NJ</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ATHEROSCLEROTIC CARDIOVASCULAR HEART DISEASE</b> YEARS DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>3/21</b> , 19 <b>84</b> , to <b>8/19</b> , 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>8/19</b> , 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Wm. R. Linthicum, M.D.</b>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <b>8/19/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>Wm. R. LINTHICUM, M.D.</b>				22e. ADDRESS <b>TANEYTON, MARYLAND 21787</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>				23b. DATE <b>8/22/84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairmount Cemetery</b>		23d. LOCATION CITY OR TOWN COUNTY STATE <b>Fairmount Hunterdon N.J.</b>			
24. FUNERAL DIRECTOR NAME ADDRESS <b>Robert Kyle Priddy Jr. Westminster, Md</b>											

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEARLY NEAR, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

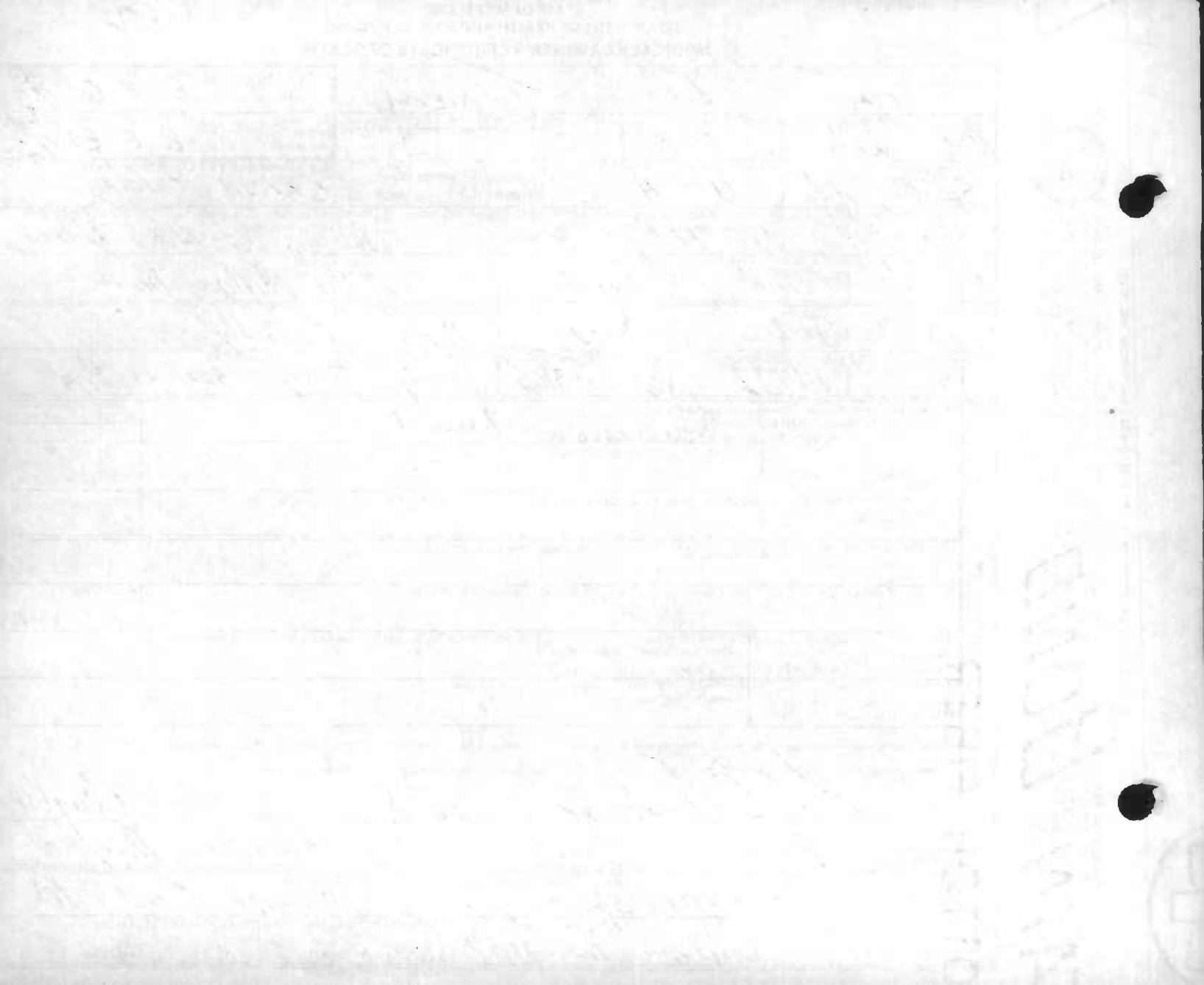
1- STATE REGISTRAR

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) <b>Thomas</b>		FIRST <b>Leo</b>		MIDDLE <b>Tracey</b>		LAST <b>Tracey</b>		2a. DATE KNOWN OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>1984</b>		2b. TIME OF DEATH HOUR <b>7</b> MIN <b>50</b>	
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH MONTH <b>12</b> DAY <b>8</b> YEAR <b>1920</b>		6. AGE (IN YEARS) LAST BIRTHDAY <b>63</b> YRS.		IF UNDER 1 YR. MONTHS <b>0</b> DAYS <b>0</b> HRS. <b>0</b> MIN.		7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>8</b> YEAR <b>1984</b>		7d. TIME OF DEATH HOUR <b>7</b> MIN <b>50</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Sparks, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County</b> MD.					
10. CITY OR TOWN OF DEATH <b>Hampstead</b>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>195 Phillips Drive</b>				12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) <b>Receiving Dept. - Block - Decker</b>			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE <b>Maryland</b>		13b. COUNTY <b>Carroll</b>		13c. CITY OR TOWN <b>Hampstead</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>195 Phillips Drive 21074</b>			
14. FATHER'S NAME FIRST <b>James</b> MIDDLE <b>Jackson</b> LAST <b>Tracey</b>		15. MOTHER'S MAIDEN NAME FIRST <b>Agnes</b> MIDDLE <b>Cassidy</b> LAST <b>Tracey</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>Yes</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) <b>NO II</b>		17. INFORMANT <b>Dr. E. Tracey</b>		ADDRESS <b>SAAC 15 4/3</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma lung</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <b>Richard D. Jones</b>				M.D. <b>Dr. E. Tracey</b>				MEDICAL EXAMINER <b>Westminster</b>			
EXAMINER'S NAME (TYPE OR PRINT) <b>Richard D. Jones</b>				ADDRESS <b>Westminster Md. 21157</b>				DATE SIGNED <b>9 Aug 84</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-11-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Westminster Cemetery</b>				23d. LOCATION CITY OR TOWN <b>Westminster</b> COUNTY <b>Carroll</b> STATE <b>Md.</b>			
24. FUNERAL DIRECTOR NAME <b>Thomas D. Fletcher</b> ADDRESS <b>Westminster Md. 21157</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 14 1984</b>				25b. REGISTRAR'S SIGNATURE <b>John R. Randle</b>			

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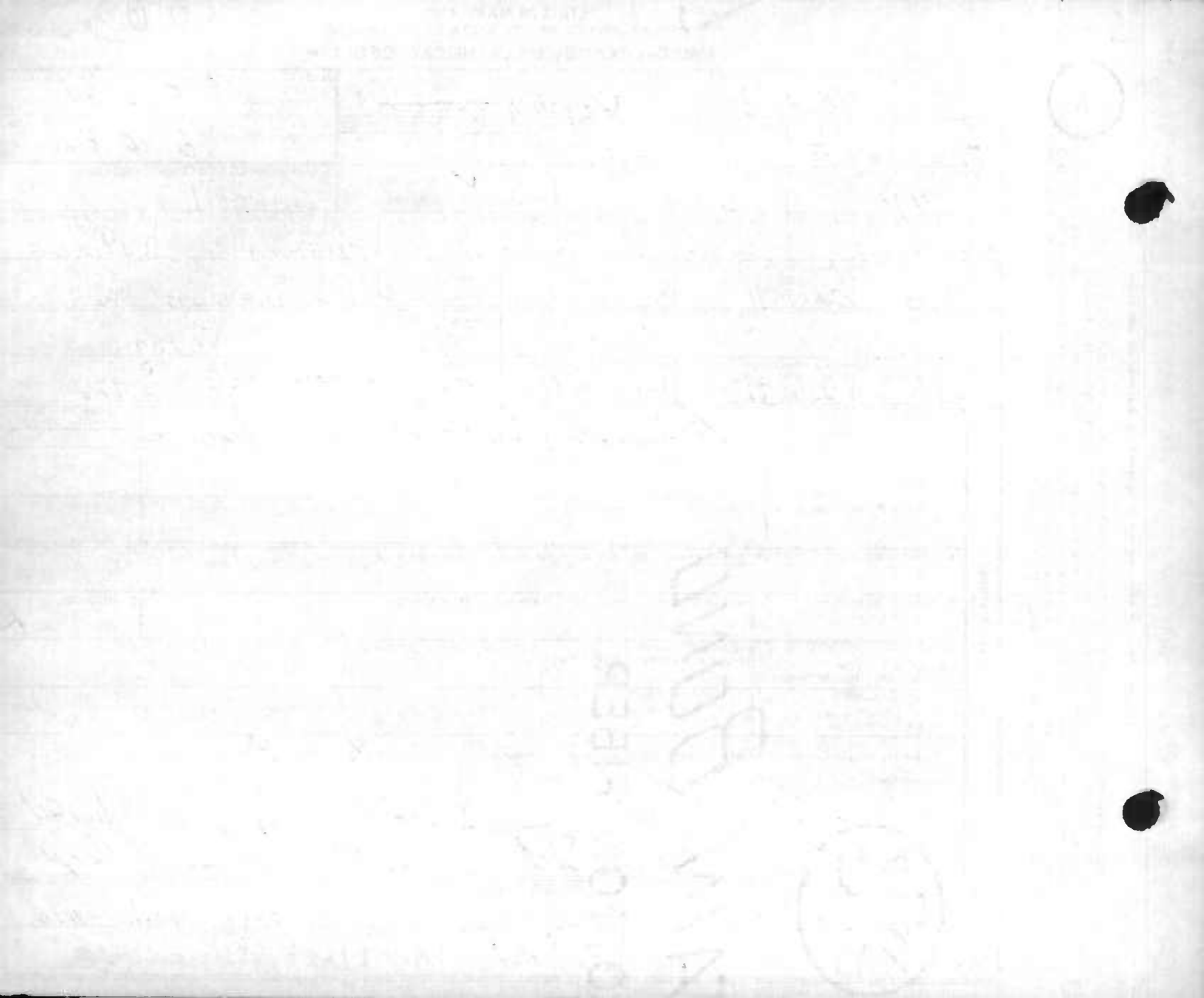
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 22003			
1. FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH						2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) <b>Clifford Vogelien</b>						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <b>8</b> DAY <b>10</b> YEAR <b>1984</b>						2b. HOUR <b>M</b>	
3. SEX <b>MALE</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH <b>1</b> DAY <b>1</b> YEAR <b>1926</b>		6. AGE (YEARS LAST BIRTHDAY) <b>58</b> YRS.		7. IF UNDER 1 YR. MONTHS <b></b> DAYS <b></b>		7c. DATE PRONOUNCED DEAD MONTH <b>8</b> DAY <b>10</b> YEAR <b>1984</b>		2d. HOUR <b>M</b>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>NY</b>				7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH <b>CARROLL</b> MD.	
10. CITY OR TOWN OF DEATH <b>Westminster</b>				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>CARROLL Co. General</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>FIREMAN</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>Baltimore</b>	
13a. STATE <b>Md</b>				13b. CITY OR TOWN <b>CARROLL</b>		13c. CITY OR TOWN <b>New Windsor</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>1763 Dennings Rd</b>			
14. FATHER'S NAME FIRST <b>William</b> MIDDLE <b></b> LAST <b>Vogelien</b>				15. MOTHER'S MAIDEN NAME FIRST <b>Louise</b> MIDDLE <b></b> LAST <b>Young</b>				16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <b>YES</b> (IF YES, GIVE WAR OR DATES) <b>WW II</b>				17. INFORMANT ADDRESS <b>MARY Vogelien 13E 21776</b>	
18. CAUSE OF DEATH (Enter only one cause per box (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Atherosclerotic Cardiovascular Disease</b>													
DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <b></b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <b></b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <b>19</b>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE <b>Richard L. Davis</b>				TITLE (SPECIFY) <b>Medical Examiner</b>				DATE SIGNED <b>10 Aug 84</b>					
EXAMINER'S NAME (TYPE OR PRINT) <b>Richard L. Davis</b>				ADDRESS <b>CARROLL County General Hosp</b>									
23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) <b>BURIAL</b>				23b. DATE <b>8-14-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EUCROGREEN</b>				23d. LOCATION CITY OR TOWN <b>Finksburg</b> COUNTY <b>CARROLL</b> STATE <b>MD</b>			
24. FUNERAL DIRECTOR NAME <b>Robert K. B. Putter</b>				ADDRESS <b>Westminster, Md</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 17 1984</b>				25b. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>	

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

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(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) <b>Katherine Slade Ward</b>					2a. DATE OF DEATH MONTH DAY YEAR <b>Aug. 13, 1984</b>			2b. HOUR MIN. <b>12:30 A.M.</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>Oct. 30, 1905</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>78</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Ky.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll Co., MD.</b>			
10. CITY OR TOWN OF DEATH <b>Westminster</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>939 Klee Mill Rd.</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Nursing</b>		12b. KIND OF BUSINESS OR INDUSTRY	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <b>Maryland</b> 13b. COUNTY <b>Carroll</b> 13c. CITY OR TOWN <b>Westminster</b>					13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>939 Klee Mill Rd. (21157)</b>		
14. FATHER'S NAME FIRST MIDDLE LAST <b>Unknown</b>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <b>275-18-4649</b>		17. INFORMANT ADDRESS <b>Betty V. Sigler, Same As #13</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Small cell Ca lung</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>CNS metastases</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <b>P.M. 19</b>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <b>8/13/84</b> to <b>8/13/84</b> , that (I) (we) lost above the deceased alive on <b>8/13/84</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.									
23. SIGNATURE <b>J. L. LICHTENFELD</b>				DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22b. DATE SIGNED <b>8/13/84</b>	
24. FUNERAL DIRECTOR NAME <b>Charles W. Burrier, Jr., Sykesville, Md.</b>				25. DATE REC'D. BY REGISTRAR <b>AUG 15 1984</b>		25b. REGISTRAR'S SIGNATURE <b>John Davidson</b>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		23b. DATE <b>8-15-1984</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Memorial</b>		23d. LOCATION <b>Finksburg, Carroll, Md.</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or on

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH	
ROBERT S. WATKINS		8 17 84	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)
Male	Caucasian	12 21 1893	90
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
Los Angeles	U.S.A.		Carroll County MD
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll Co. Gen. Hosp.	Real Estate	Land
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	Carroll	Sykesville	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	13e. STREET ADDRESS	
Edward Harris Watkins	Antoinette Maisch	4608 McNevin Ave. 21784	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS	
yes	U.S.W.I.	Helen A. Watkins	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) Pneumonia			
DUE TO, OR AS A CONSEQUENCE OF (b) Parkinson's disease			
DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8/21 19 79 to 8/17 19 84, that (I) (we) lost saw the deceased alive on 8/24/84 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) did not view the body after death.			
22b. SIGNATURE		DEGREE	22c. DATE SIGNED
[Signature]		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	8/17/84
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE
Burial	8-20-84	Springfield Cemetery	Sykesville Maryland
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D BY REGISTRAR	
Harry W. Haight		AUG 21 1984	
ADDRESS		REGISTRAR'S SIGNATURE	
Sykesville		Julia Davidson-Russell	

BP

400-11-11111111  
11/11/11

2011/11/11  
Dear Sir,  
I am writing to you regarding the matter of the  
contract for the supply of goods and services.  
I have received your letter of the 11th of November  
and I am sorry to hear that you are not  
satisfied with the quality of the goods.  
I have spoken to the relevant departments and  
we are working to resolve the issue as quickly  
as possible. I will contact you again once a  
solution has been reached.  
Yours faithfully,  
[Signature]  
[Name]  
[Title]



11/11/11

2011/11/11

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

## MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Weigle				2a. DATE OF DEATH MONTH DAY YEAR 11 Aug 84				2b. HOUR 1025 AM			
3. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR August 15 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL Co General				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Editor		12b. KIND OF BUSINESS OR INDUSTRY PAPER			
13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 115 Liberty 21157			
14. FATHER'S NAME FIRST MIDDLE LAST John Weigle				15. MOTHER'S MAIDEN NAME FIRST MIDDLE Ruffina Frostle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no none				16b. SOCIAL SECURITY NO. 327-28-1090		17. INFORMANT Edith Weigle		ADDRESS 13e 21157			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respirator arrest DUE TO, OR AS A CONSEQUENCE OF (b) Pulm. failure, acute DUE TO, OR AS A CONSEQUENCE OF (c) Bleeding Duodenal Ulc.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 min 3 days 21 days	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Colon cancer											
19a. DATE OF OPERATION 15 July 84				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Duodenal Ulc.				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (the hospital) attended the deceased from 15 July 1984, to 11 Aug 1984, that (1) (we) last saw the deceased alive on 10 Aug 1984, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (do) not view the body after death.											
22b. SIGNATURE Donald D. Coker MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 11 Aug 84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald D. Coker MD				22e. ADDRESS 222 Washington Heights Medical Center Westminster, Md 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-14-84		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll MD			
24. FUNERAL DIRECTOR NAME Robert Kay Priddy Jr.				ADDRESS Westminster, Md.		25a. DATE REC'D. BY REGISTRAR AUG 17 1984		25b. REGISTRAR'S SIGNATURE John Davidson-Randall			

BP



20% COLLUM



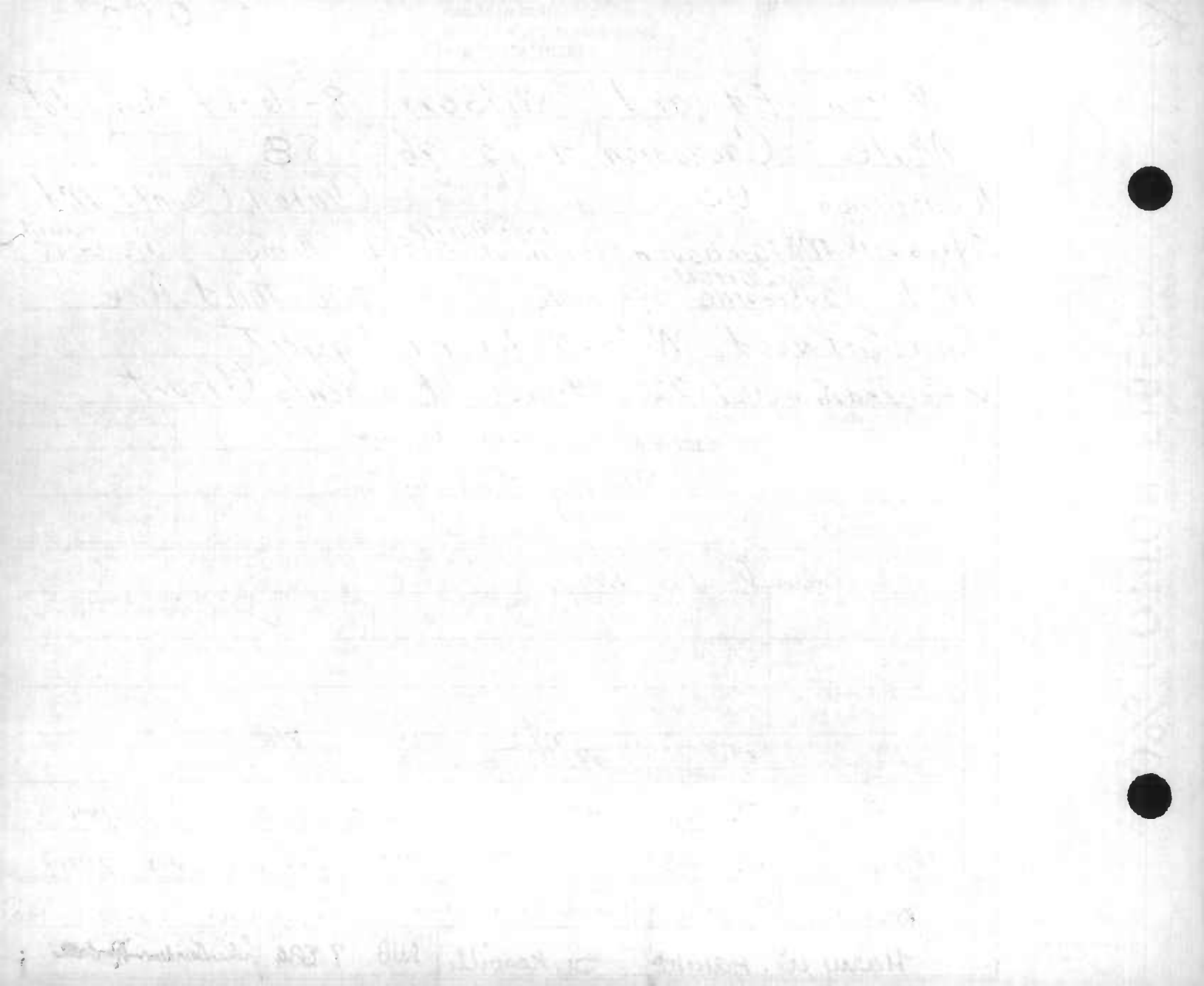
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

## MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <b>Milton Edward Wilson</b>				2a. DATE OF DEATH MONTH DAY YEAR <b>8-6-84 Mon</b>				2b. HOUR <b>1:40 P</b>			
3. SEX <b>Male</b>		4. RACE <b>Caucasian</b>		5. DATE OF BIRTH MONTH DAY YEAR <b>7-12-96</b>		6. AGE (IN YEARS LAST BIRTHDAY) <b>88</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <b>Pennsylvania</b>		7b. CITIZEN OF WHAT COUNTRY? <b>US</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <b>Carroll County Md.</b>					
10. CITY OR TOWN OF DEATH <b>Sykesville Md.</b>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <b>Fairhaven Retirement 21784</b>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <b>Army</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired U.S. GOVT</b>			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <b>Md. Sykesville</b>		13b. COUNTY <b>Carroll</b> CITY OR TOWN <b>Sykesville</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <b>7200 Third Ave. 21784</b>					
14. FATHER'S NAME FIRST MIDDLE LAST <b>John Kirkwood Wilson</b>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <b>Laura Eggert</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <b>Retired Army (Col.)</b>				16b. SOCIAL SECURITY NO. <b>220-44-0161</b>				17. INFORMANT ADDRESS <b>Residents Chart</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Melanotic Colonic Carcinoma</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Curry's Prost. Infection</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sarcotoma</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Abdominal Wall Abscess</b>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER).				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <b>8/6</b> 19 <b>84</b> , to <b>8/6</b> 19 <b>84</b> , that (I) (we) lost saw the deceased alive on <b>8/6</b> 19 <b>84</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Patrick A. Turnes</b>				DEGREE <b>MD</b>				22c. DATE SIGNED <b>8/6/84</b>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <b>PATRICK TURNES MD</b>				22e. ADDRESS <b>7200 3rd Ave Sykesville, MD 21784</b>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Cremation</b>		23b. DATE <b>8-7-84</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Carroll Cremation</b>				23d. LOCATION CITY OR TOWN COUNTY STATE <b>Hampstead Carroll MD</b>			
24. FUNERAL DIRECTOR NAME <b>Harry W. Haight</b> ADDRESS <b>Sykesville</b>				25a. DATE REC'D. BY REGISTRAR <b>AUG 7 1984</b>		25b. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					



STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

1- FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Dora James Wink			2a. DATE OF DEATH MONTH DAY YEAR 8 17 84			2b. HOUR 3 AM				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 16 94		6. AGE (IN YEARS LAST BIRTHDAY) 890 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH Manchester		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Long View Nsg Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer		12b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		
13a. STATE Md.			13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS / ZIP CODE 4311 Maple Grove Road 21771	
14. FATHER'S NAME FIRST MIDDLE LAST Henry J Wink			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Bixler							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-36-0491A		17. INFORMANT ADDRESS Charlotte Streig 5111 Hanover Pike Manchester, Md. 21102					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 MIN 5 yrs.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Parkinson's Disease - Senile Dementia										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Sept 19 84 to Aug 17 19 84, that (I) (we) lost saw the deceased alive on Aug 7 19 84, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE W H Foard MD			DEGREE			22c. DATE SIGNED 8/12/84				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W H Foard MD			22e. ADDRESS 3223 N 4th St Box E Manchester, Md 21102							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/19/84		23c. NAME OF CEMETERY OR CREMATORY IMMANUEL LUTHERAN		23d. LOCATION CITY OR TOWN COUNTY STATE MANCHESTER CARROLL MD.			
24. FUNERAL DIRECTOR NAME Eckhardt Funeral Home MANCHESTER, MD.			25a. DATE REC'D. BY REGISTRAR 21			25b. REGISTRAR'S SIGNATURE John Davidson-Randall				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, any injury, or other traumatic event, the medical examiner must be notified.

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Handwritten notes and diagrams on lined paper, including a table with columns labeled "Date", "Time", "Place", and "Remarks". The text is mostly illegible due to blurriness and bleed-through from the reverse side. A large, faint "A" is visible in the upper right corner, and a large, faint "B" is visible in the lower right corner. There are also some small, faint diagrams or sketches scattered throughout the page.

STATE OF MARYLAND  
DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1- FOR  
STATE  
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) LOUISE Amelia ZOELLER			2a. DATE OF DEATH MONTH DAY YEAR 08 19 84			2b. HOUR 630 AM				
3. SEX Female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 05 04 94		6. AGE (IN YEARS LAST BIRTHDAY) 90		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.				
10. CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) GOLDEN AGE GUEST HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE MD			13b. COUNTY CARROLL		13c. CITY OR TOWN SYKESVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 502 Danmarth Rd 21784	
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Strupp			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jennie Rieger							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) --- 216-46-2614		17. INFORMANT Finksborg, MD ADDRESS 21048 Lot 133 M/M Charles Griffin 4600 Sykesville Rd					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ATHEROSCLEROTIC CARDIOVASCULAR DISEASE</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YEARS		
DUE TO, OR AS A CONSEQUENCE OF (b) _____										
DUE TO, OR AS A CONSEQUENCE OF (c) _____										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>10/29/78</u> to <u>8/19</u> 19 <u>84</u> , that (I) (we) last saw the deceased alive on <u>8/16</u> 19 <u>84</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Wm R. LINTHICUM, M.D.</u>					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/19/84			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm R. LINTHICUM, M.D.					22e. ADDRESS TANEXTOWN, MD. 21787					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/21/84		23c. NAME OF CEMETERY OR CREMATORY Western Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore City, MD			
24. FUNERAL DIRECTOR NAME Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133					25. DATE REC'D. BY REGISTRAR AUG 22 1984		25b. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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WAX  
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